

Objective 3

Investing in People

3.1 - Health

3.1.1 – HIV/AIDS

Indicator #T1.1.D	3.1.1-6 New: Number of adults and children with advanced HIV infection newly enrolled on ART		
Type of Indicator:	Direct		
Numerator:	Number of adults and children with advanced HIV infection newly enrolled on ART		
Denominator:	N/A		
Disaggregation:	Essential/reported	<1	
	<i>Recommended</i>	<5	
	Essential/reported	<15 Males	
	Essential/reported	<15 Females	
	Essential/reported	15+ Males	
	Essential/reported	15+ Females	
	Essential/reported	Pregnant Women	
Purpose:	Measures scale-up of ART program and for pregnant women disaggregation offers a measure of the linkages between PMTCT and treatment programs.		
Applicability:	All countries with PEPFAR-funded partners supporting direct ART services should report on this indicator. This indicator should be reported for PEPFAR Directly supported sites.		
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, i.e. quarterly, for the purposes of program management and review.		
Measurement tool:	Facility ART registers/databases, program monitoring tools, or drug supply management systems		
Method of measurement:	The numerator can be generated by counting the number of adults and children who are newly enrolled in ART in the reporting period, in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards). Patients with records that transfer in from another facility, or who temporarily stopped therapy and have started again in the time period should not be counted. ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are eligible for and initiate antiretroviral drug therapy for their own treatment are included in this indicator. The number of adults and children with advanced HIV infection who are newly receiving ART can be obtained through data collected from drug supply management systems or facility-based ART registers. NEW is a state defined by an individual's beginning in a program, it is expected that the characteristics of new clients are recorded at the time they newly initiate into a program. Patients are counted as pregnant if they were pregnant at initiation of ART. Age represents an individual's age at initiation of therapy. For example, if a 14 year old child begins ART and then shortly after turns age 15, the child will still be counted under NEW in the <15 age category. According to "WHO CASE DEFINITIONS OF HIV FOR SURVEILLANCE AND REVISED CLINICAL STAGING AND IMMUNOLOGICAL CLASSIFICATION OF HIV-RELATED DISEASE IN ADULTS AND CHILDREN (2007) • Clinical criteria for diagnosis of advanced HIV in adults and children with confirmed HIV infection: Presumptive or definitive diagnosis of any stage 3 or stage 4 condition. and/or; • Immunological criteria for diagnosing advanced HIV in adults and children five years or older with confirmed HIV infection: CD4 count less than 350 per mm3 of blood in an HIV-infected adult or child.		

	and/or; • Immunological criteria for diagnosing advanced HIV in a child younger than five years of age with confirmed HIV infection: %CD4+ <30 among those younger than 12 months; %CD4+ <25 among those aged 12–35 months; %CD4+ <20 among those aged 36–59 months. However, according to WHO pediatric ART guidelines (2008), all infants under 12 months of age with confirmed HIV infection should be started on ART, irrespective of clinical or immunological stage, or where virological testing is not available, infants under 12 months of age with clinically diagnosed presumptive severe HIV should start ART and confirmation of HIV infection should be obtained as soon as possible. Thus, infants under 12 months of age need not have a diagnosis of advanced HIV to be counted in this indicator. The “essential/reported” disaggregation of <1 year old is a subset of the age group <15 years old.
Interpretation:	This indicator permits monitoring trends in initiation but does not attempt to distinguish between different forms of ART or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. CURRENT is a state defined by vital/treatment status when last seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. On the contrary, NEW and CUMMULATIVE are states defined by beginning in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program and will remain at that same status over time.
Additional information:	Refer to the PEPFAR Treatment Indicator TWG with further inquiries

Indicator #T1.2.D	3.1.1-10 Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	
Type of Indicator:	Direct	
Numerator:	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	
Denominator:	N/A	
Disaggregation:	Essential/reported	<1
	<i>Recommended</i>	<5
	Essential/reported	<15 Males
	Essential/reported	<15 Females
	Essential/reported	15+ Males
	Essential/reported	15+ Females
Purpose:	To assess progress towards providing ART to all people with advanced HIV infection; Coverage; Track progress towards legislative 5-year goals.	
Applicability:	All countries with PEPFAR-funded partners supporting direct ART services should report on this indicator. This indicator should be reported for PEPFAR Directly supported sites.	
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, i.e. quarterly, for the purposes of program management and review.	
Measurement tool:	<u>Numerator</u> : Facility ART registers/databases, program monitoring tools, or drug supply management systems.	
Method of measurement:	Data for this indicator can be generated by counting the number of adults and children who are currently receiving ART in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period. The numerator should equal the number of adults and children with advanced HIV infection who ever started ART minus those patients who are not currently on treatment prior to the end of the reporting period. Patients excluded from the numerator are patients who died, stopped treatment, transferred out or are lost to follow-up (patient not seen for 3 months from last visit). Patients on ART who initiated or transferred in during the reporting period should be counted. Patients that pick up several months of antiretroviral drugs at one visit, which could include ART received for the last months of the reporting period, but not be recorded as visits for the last months should be included in the count. ART taken only for the purpose of prevention of mother-to-child transmission and post-exposure prophylaxis are not included in this indicator. HIV-positive pregnant women who are eligible for and on antiretroviral drugs for their own treatment are included in this indicator. The number of adults and children with advanced HIV infection who are currently receiving ART can be obtained through data collected from drug supply management systems or facility-based ART registers. Patients receiving ART in the private sector and public sector should be included in the numerator for the country as a whole. CURRENT is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. Age represents an individual's age at the end of the reporting period or when last seen at the facility. For example, a 14-year-old child will be counted as currently receiving treatment in the <15 age category at the end of reporting period "A". During reporting period "B" the child turns age 15 and so at the end of this reporting period the child will be counted under the 15+ age category.	

	SEE INDICATOR #T1.1.D FOR THE WHO CASE DEFINITIONS OF HIV FOR SURVEILLANCE AND REVISED CLINICAL STAGING AND IMMUNOLOGICAL CLASSIFICATION OF HIV-RELATED DISEASE IN ADULTS AND CHILDREN (2007)
Interpretation:	This indicator permits monitoring trends in coverage but does not attempt to distinguish between different forms of ART or to measure the cost, quality or effectiveness of treatment provided. These will each vary within and between countries and are liable to change over time. The proportion of people needing ART varies with the stage of the HIV epidemic and the cumulative coverage and effectiveness of ART among adults and children. The degree of utilization of ART will depend on factors such as cost relative to local incomes, service delivery infrastructure and quality, availability and uptake of voluntary counseling and testing services, and perceptions of effectiveness and possible side effects of treatment. A basic level of retention (or attrition) can be calculated as current clients divided by cumulative clients; that is the proportion of clients that remain on ART at the end of the reporting period of those ever started on ART. Since age and pregnancy status change over time, the comparison of NEW, CUMULATIVE, and CURRENT clients by age and pregnancy status is challenging. CURRENT is a state defined by vital/treatment status when <i>last</i> seen, so it is expected that characteristics of these clients would be updated each time they are seen by a program. On the contrary, NEW and CUMMULATIVE are states defined by <i>beginning</i> in a program, it is expected that the characteristics of new and cumulative clients are recorded at the time they newly initiate or transfer into a program and will remain at that same status over time.
Additional information	- #4, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 • Treatment indicator (HIV-T1), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M E Toolkit P2-HIV en.pdf

Indicator #P11.1.D	3.1.1-24 Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results		
Type of Indicator:	Direct		
Numerator:	Number of individuals who received T&C services for HIV and received their test results during the past 12 months		
Denominator:	N/A		
Disaggregation:	Essential/reported	By Sex: Male, Female	
	Essential/reported	By Age: <15, 15+	
	Essential/not reported	By test result: Positive, Negative	
	Recommended	By type of counseling: Individual, Couples*	
	Recommended	By MARP type: CSW, IDU, MSM	
Purpose:	This indicator is intended to monitor trends in the uptake of HIV T&C services over time within a country, regardless of the type of T&C service delivery method. The recommended levels of disaggregation are intended to monitor access to and uptake of HIV T&C by specific populations that are most affected by the epidemic. Data could also be useful for projecting programmatic needs such as test kits and other staffing resources, although individuals are counted.		
Applicability:	All countries with PEPFAR-funded partners directly supporting testing and counseling services regardless of where the service is being delivered, including T&C services to TB patients, pregnant women, and infants.		
Data collection frequency:	Data should be collected, reviewed, and cleaned continuously at the facility level (or community level). Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly for the purposes of program management and review.		
Measurement tool:	Existing T&C registers and reporting forms that are already being used to capture HIV T&C encounters could be revised to include the disaggregation categories. Examples of data collection forms include client intake forms, activity report forms, or health registers such as STI registers, HMIS registers and NGO records.		
Method of measurement:	Data for the numerator should be generated by counting the total number of individuals who received HIV T&C from any service delivery point. Service delivery points could include fixed health care facilities such as, hospitals, public and private clinics, VCT, ANC, L&D, PMTCT, or TB sites; standalone sites such as free standing sites not associated with medical institutions; and, mobile testing such as, HIV T&C services offered in a specific location for a limited period of time, e.g. outreach, door-to-door services and workplace testing events. All individuals receiving T&C should be counted in this indicator regardless of where the service is provided. These individuals will include TB patients, pregnant women, men receiving circumcision, and infants. To adequately collect data for this indicator, a minimum provision of the following services is required: counseling, testing, return and receipt of test results. *Couples counseling describe those sessions where two or more people in a relationship come together for HIV T&C services. If a couple comes for services together, they should be counseled together and receive their test results together, where possible. When this happens data should be collected for each individual and it should be indicated on the		

	form that this was a couple session as opposed to an individual session.
Interpretation:	This indicator is intended to monitor individuals and the trends in the uptake of testing and counseling over time. However, in some cases, data for this indicator might include repeat testers. If data on persons who retest are not available, this indicator will give information on the number of times HTC services were delivered, rather than the number of individuals who received HTC services. Repeat testing is common practice among most HIV T&C programs and it is important to recognize this and interpret the aggregated data with caution. Over time, the number of people who are expected to be tested and counseled within a country will vary depending on numerous factors such as, the numbers of people with previously confirmed positive status, or the number of people who may be at perceived risk of HIV infection, and hence this indicator should be interpreted accordingly. In addition, the type and focus of a T&C program for each respective country has an impact on its interpretation. For example, a program that targets high-risk groups or areas of highest prevalence, may have smaller numbers tested, and yet higher yield in HIV infection identification than a program providing general T&C services. Given that this indicator is intended to count individuals and not tests, data produced through this indicator would need further interpretation for use in commodities planning. Finally, this indicator does not provide information on whether those who were tested were adequately referred to and are receiving follow up services to benefit from knowing their HIV status.
Additional Information:	- Partially harmonized with #7, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf • Partially harmonized with Prevention indicator (HIV-P8b), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Indicator #P1.2.D	3.1.1-39 Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission
Type of Indicator:	Direct
Numerator:	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission
Denominator:	Number of HIV- positive pregnant women identified in the reporting period (including known HIV- positive at entry)
Disaggregation:	By regimen type (all essential/reported): 1. Antiretroviral therapy for HIV-infected pregnant women eligible for treatment 2. Maternal triple ARV prophylaxis (Includes the following AZT-based regimens, when all three drugs are started simultaneously (AZT/3TC/LPVr, AZT/3TC/ABC, AZT/3TC/EFV. This is comparable to the “Option B” regimens in the WHO’s recently released PMTCT guidelines) 3. Maternal AZT (This includes regimens with AZT as the primary prophylactic agent regardless of the duration and receipt of other drugs should be included in this category. This is comparable to the “Option A” regimens in the WHO’s recently released PMTCT guidelines) 4. Single Dose Nevirapine (SD-NVP)
Purpose:	This indicator measures the delivery and uptake of antiretroviral prophylaxis, by regimen type, for the prevention of mother-to-child-transmission (PMTCT). The risk of MTCT can be significantly reduced with the use of antiretrovirals for the mother, with or without prophylaxis to the infant. The disaggregation by regimen type provides data used by SPECTRUM and other models and applications to determine the impact of PMTCT programs, by country. These data will be important to PEPFAR Headquarters, TWGs and USG country-level managers in order to: • Identify progress toward the USG goal of reaching 80% of HIV-positive pregnant women and reducing transmission by 40% • Determine the impact of national and USG-supported PMTCT programs • Determine countries’/ partners’ progress at implementing more efficacious PMTCT ARV programs • Identify countries/ partners needing assistance to implement more efficacious regimens, according to international standards
Applicability:	All countries with PEPFAR funded partners supporting PMTCT direct service delivery
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Facility registers and other program monitoring tools
Method of measurement:	The numerator can be generated by counting the number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT during the reporting period, by regimen. <u>Explanation of Numerator:</u> The number of HIV-positive pregnant women who received antiretrovirals to reduce MTCT is obtained from program monitoring records compiled from patient records and facility registers. ARVs can be provided to HIV-positive women during pregnancy, at labor, and shortly after delivery (i.e. within 72 hours or according to national/international standards) across a number of sites to prevent mother to child transmission of HIV, including at ANC, L&D, and care and treatment. Numerator data will be stratified by maternal regimen: 1. Single-dose Nevirapine only 2. Prophylactic regimens using a combination of 2 ARVs

3. Prophylactic regimens using a combination of 3 ARVs

4. ART for HIV-positive pregnant women eligible for treatment¹

Each ARV regimen category is mutually exclusive. ARVs can be provided to HIV-positive women at many sites including ANC, L&D and care & treatment. If a woman switches regimens within one reporting period, she should be counted only once. Count the most recent regimen provided to her in the reporting period. If Nevirapine is given after AZT this will be counted as two-drug. HIV-positive women receiving any of the above regimen categories meet the definition of the numerator.

¹The categories can be clarified as follows:

Categories	Further clarification	Examples
a) Single-dose nevirapine only	One dose of nevirapine for mother given at or around birth	Single-dose (SD) NVP
b) Prophylactic regimens using a combination of two ARV;	A prophylactic regimen that uses more than one ARV drug for mothers to prevent HIV transmission and is started before labour and delivery	AZT + SD NVP AZT + SD NVP +7 day post-partum tail of AZT/3TC AZT + 3TC AZT + 3TC + SD NVP
c) Prophylactic regimens using a combination of three ARVs	Highly active regimen for MTCT prophylaxis designed to fully suppress viral replication prior to and during delivery and for a variable duration post partum	AZT + 3TC + NNRTI or AZT + 3TC +PI or AZT + 3TC + NRTI
d) ART for HIV-positive pregnant women eligible for treatment	ART for HIV-positive pregnant women eligible for treatment (estimate < 2% trans)	Standard national treatment regimen AZT + 3TC + NNRTI or AZT + 3TC +PI or AZT + 3TC + NRTI

Two methods for calculating the numerator can be used:

1) Low facility delivery settings:

Counting at point of ARV provision: In settings with low facility deliveries, data for the numerator should be compiled from patient registers based on where ARVs are dispensed and where the data is being recorded. For example, where ARV prophylaxis is provided in the ANC and ART is provided in the care and treatment unit, countries should aggregate data from the ANC/PMTCT register as well as the pre-ART or ART register. There is a risk of double counting in settings where ARVs are provided at different points in time and/or in different service units or health facilities (e.g. a woman received SD-NVP at post-test counseling and then received AZT at 28 weeks). Countries should ensure a data collection and reporting system is in place to minimize the potential for double counting.

2) High facility deliver settings:

Counting at the end-point of labor and delivery: In settings with high facility delivery rates (>90%), countries can aggregate the numerator entirely from the L&D register by counting the number of HIV-positive pregnant women who had received a specific ARV regimen by the time of delivery (e.g., a woman received SD-NVP and AZT during her pregnancy; at the time of delivery she would be recorded in the L&D register as having received AZT+SD-NVP during pregnancy and included in category #2). This may be the most reliable and accurate method for calculating this indicator for settings with high facility deliveries, as the corresponding ARV regimen dispensed is counted at the end of a woman's pregnancy.

	<u>PEPFAR denominator:</u> This denominator will include a sum of categories a-d below, at USG-supported sites: a) number of pregnant women who received an HIV+ test and result during ANC b) pregnant women attending L&D with <i>unknown</i> HIV status who were tested HIV+ in the L&D and received their results c) pregnant women with <i>known</i> HIV infection attending ANC for a new pregnancy d) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested HIV positive
Interpretation:	This indicator allows countries to monitor: 1) the coverage of antiretrovirals given to HIV-positive pregnant women to reduce the risk of HIV transmission to the child; and 2) increased access to more efficacious ARV regimens for PMTCT in countries that are scaling up newer regimen categories. One weakness of this indicator is the exclusion of mother-infant pairs who only received infant prophylaxis. Therefore, partial prophylaxis for the infant only is not measured. The indicator measures ARVs dispensed and not ARVs consumed, thus it is not possible to determine adherence to the ARV regimen.
Additional Information:	- #5, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 - Prevention indicator (HIV-P12), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Indicator #P1.1.D	3.1.1-59 Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)
Type of Indicator:	Direct
Numerator:	Number of pregnant women who were tested for HIV and know their results.
Denominator:	Number of new ANC and L&D clients
Disaggregation:	By: Known positives at entry Number of new positives identified
Purpose:	This indicator reflects one goal of PMTCT, which is to increase the number of pregnant women who know their HIV status. Identification of a pregnant woman's HIV status is the key entry point into PMTCT services and other HIV care and treatment services. These data will be important to PEPFAR Headquarters, TWGs and USG country-level managers in order to: • Identify progress toward the USG goal to reach 80% of pregnant women with HIV testing and counseling • Determine PEPFAR and PEPFAR-funded partners' performance in providing HIV testing to pregnant women • Identify countries/ partners needing assistance with program implementation
Applicability:	All countries with PEPFAR funded partners supporting PMTCT direct service delivery
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Facility registers and other program monitoring tools
Method of Measurement	The numerator is a composite of the following two data components: The number of women with known (positive) HIV infection attending ANC for a new pregnancy over the last reporting period The number of women attending ANC, L&D who were tested for HIV and received results (<i>These should also be counted in indicator #P11.1.D</i>) The numerator can be summed from categories a-d below: a) Number of pregnant women who received an HIV test and result during ANC b) Number of pregnant women attending L&D with unknown HIV status who were tested in the L&D and received results c) Women with unknown HIV status attending postpartum services within 72 hours of delivery who were tested and received results d) Pregnant women with known HIV infection attending ANC for a new pregnancy. <u>Explanation of Numerator:</u> The numerator is calculated using national and/or PEPFAR program records aggregated from facility registers in the ANC and L&D. In countries with high L&D attendance rates (>90%), data can be collected from L&D registers only. Health facility registers should reflect known HIV infection among HIV-positive pregnant women coming to the ANC for a new pregnancy, such as through a code, circle, or other method, in order for them to receive subsequent PMTCT interventions. <i>Pregnant women with unknown status:</i> women who were not tested during ANC or at L&D for this pregnancy or did not have documented proof of having been tested during ANC or at L&D for this pregnancy. <i>Pregnant women with known HIV-infection:</i> women who were tested and confirmed HIV-positive at any point prior to the current pregnancy, who are attending ANC for a new

	pregnancy. Pregnant women with known HIV infection attending ANC for a new pregnancy do not need retesting if that is in line with the national guidelines on testing pregnant women and/or, as long as they bring documented proof of their positive status with them. However, these women do need subsequent PMTCT services, and so should be counted in the numerator. In this case, documented proof may include (but is not limited to), a health card with HIV status noted in it, test results from another testing center, or any other document that denotes that the bearer of the document is HIV positive. <u>PEPFAR denominator:</u> The total number of new clients attending ANC and L&D services at USG-supported sites should be used as the denominator. This total will include the number of new clients who attend PMTCT services at USG-supported ANC sites and the number of women who present at L&D sites supported by USG with unknown status (as a proxy for those who have not attended ANC with PMTCT services). USG country team is to identify the best source of data for unduplicated individuals. If the country has high facility delivery rates (>90%), the L&D data may be used as the denominator, otherwise ANC data should be used. Note: This indicator is meant to measure the number of pregnant women who know their HIV status and is not meant to provide programmatic guidance around the types of services that should accompany HIV testing (i.e. counseling). All HIV testing programs should be adhere to national or international standards.
Interpretation:	This indicator enables the USG PEPFAR team to monitor trends in HIV testing among pregnant women and uptake of testing at USG-funded sites. The points at which drop-outs occur during the testing and counseling process and the reasons why they occur are not captured by this indicator. This indicator does not measure the quality of the testing or counseling. It also does not capture the number of women who received pre- or post- test counseling. There is a risk of double counting with this indicator, as a pregnant woman could be tested multiple times during ANC, L&D, or postpartum. This is particularly true where women get re-tested in different facilities, or where they come to the L&D without documentation of their test. While not feasible to avoid double counting entirely, countries should ensure a data collection and reporting system is in place to minimize it, such as using patient held and facility held ANC records to document that testing took place.
Additional Information:	- #7, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversion_en.pdf - Partially harmonized with Prevention indicator (HIV-P11), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf - IATT PMTCT M&E Guidance

Indicator #P4.1.D	3.1.1-62 Number of injecting drug users (IDUs) on opioid substitution therapy
Type of Indicator:	Direct
Numerator:	Number of injecting drug users (IDUs) on opioid substitution therapy
Denominator:	Total estimated number of IDUs *Recommended at partner level only
Disaggregation:	N/A
Purpose:	Medication-assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Substance abuse treatment reduces the frequency of drug use which in turn reduces HIV risk behaviors (Metzger, 1993, Gowing, 2008, and IOM, 2006). It also improves adherence to disease treatment regimens (Gowing, 2008 and IOM, 2006). Treatment modalities include non-pharmacological and pharmacological approaches; often, a combination of the two is used (National Institute on Drug Abuse, 1999b). An extensive body of evidence shows that medication assisted therapy (MAT) reduces the frequency of heroin injection and improves substance abuse treatment retention (Gowing, et al, 2008). Methadone maintenance therapy (MMT) is associated with reduced HIV risk behaviors including reduced frequency of injecting and sharing of injection equipment, reductions in the number of sex partners, and exchanges of sex for drugs or money (Gowing, et al, 2008) Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services. It is important to know how many people are reached in order to monitor how well programs are reaching IDUs with medication-assisted treatment. This information can be used to plan and make decisions on how well an IDU audience is being reached with medication-assisted treatment. If a small percentage of the intended audience is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement medication-assisted IDU treatment programs.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	<u>Explanation of Numerator:</u> The numerator is generated by counting the total number of individuals who have been on treatment for at least 3 months since initiation of opioid substitution therapy or medication-assisted treatment (e.g. using methadone or buprenorphine to treat drug dependency in order to reduce frequency of injections and potentially reduce other behavioral risk factors) at any point in time within the reporting period. The numerator should equal the number of adults who initiated and remain on opioid substitution therapy or medication-assisted treatment for at least 3 months prior to the end of the reporting period. Adults who initiated or transferred in during the reporting period should be counted only if they have been on treatment for at least 3 months after initiation prior to the end of the reporting period.

	Count all individuals who complete at least 3 months of treatment even if they drop-out, die, or are otherwise lost to follow-up. Do not count individuals who initiate treatment too late in the reporting period to be able to reach a minimum of 3 months. These individuals will be counted in the next reporting period assuming they complete at least 3 months of treatment. <i>For example: If an adult initiates his/her treatment in the last few months of reporting period, however, s/he does not complete at least 3 months in treatment before the end of the reporting period, then count this individual in the next reporting period.</i> It is highly recommended that PEPFAR Teams have systems in place to monitor individuals who have been on opioid substitution therapy or medication-assisted treatment for different time intervals: for at least 3 months, for at least 6 months, for at least 12 months, etc. Partners providing referrals only should not use this indicator. See MARP Indicator #P8.3.D for possible alternative. <u>Explanation of Denominator (recommended at partner level):</u> Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. IDU estimates for subdistricts/districts/regions can be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of IDUs that received medication-assisted therapy. These interventions are based on evidence. The information collected will allow the country and the PEPFAR to assess any changes in risk behaviors as a result of the implemented interventions. The information will also help the country to understand the efficacy and effectiveness of evidence-based interventions and help in further expansion of similar interventions.
Additional Information	- Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries - http://www.aidsmap.com/en/news/93E2DEB4-9AC2-4DFC-A236-4F910CA7016A.asp

Indicator #P5.1.D	3.1.1-63 Number of males circumcised as part of the minimum package of MC for HIV prevention services																						
Type of Indicator:	Direct																						
Numerator:	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego <i>Manual for Male Circumcision Under Local Anesthesia</i> ¹																						
Denominator:	N/A																						
Disaggregation:	<table border="1"> <tr> <td>Essential/Reported</td><td><1</td></tr> <tr> <td>Essential/Reported</td><td>1-14</td></tr> <tr> <td>Essential/Reported</td><td>15+</td></tr> </table> <table border="1"> <tr> <td>Recommended for in country partner level tracking</td><td><1</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>1-9</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>10-14</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>15-19</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>20-24</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>25-34</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>35-49</td></tr> <tr> <td>Recommended for in country partner level tracking</td><td>50+</td></tr> </table> Recommended for in country partner level tracking: HIV positive by test(s) on site HIV negative by test(s) on site HIV indeterminate result by test(s) on site Unknown/refused HIV test Documented HIV positive result Documented HIV negative result Recommended for in country partner level tracking: Fixed/permanent location Temporary (including mobile) location 	Essential/Reported	<1	Essential/Reported	1-14	Essential/Reported	15+	Recommended for in country partner level tracking	<1	Recommended for in country partner level tracking	1-9	Recommended for in country partner level tracking	10-14	Recommended for in country partner level tracking	15-19	Recommended for in country partner level tracking	20-24	Recommended for in country partner level tracking	25-34	Recommended for in country partner level tracking	35-49	Recommended for in country partner level tracking	50+
Essential/Reported	<1																						
Essential/Reported	1-14																						
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Recommended for in country partner level tracking	25-34																						
Recommended for in country partner level tracking	35-49																						
Recommended for in country partner level tracking	50+																						
Purpose:	Three randomized controlled clinical trials in sub-Saharan Africa demonstrated a 60% reduction in risk of female-to-male HIV transmission among men randomized to receive circumcision (compared to uncircumcised controls). ^{2,3,4} This evidence is supported by long-standing ecologic and observational data. Elective surgical male circumcision confers a partially protective effect against HIV acquisition for HIV-negative men at risk for acquiring HIV from HIV-positive female sexual partners, and may be particularly beneficial in populations where HIV prevalence is high and male circumcision prevalence is low. For maximal population impact, uptake of male circumcision should be as high and as rapid as safely possible and aligned with national policy. The total number of males circumcised indicates either change in the supply of or demand for MC services. Additionally, disaggregated information may be useful to evaluate whether prioritized services have been successful, set targets have been achieved, and modeling inputs should be adjusted.																						
Applicability:	All countries with PEPFAR-funded partners providing the MC minimum package of services should report on this indicator.																						
Data collection frequency:	Data should be collected continuously at the program/site level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. monthly or quarterly, for the purposes of program management and																						

	review.
Measurement tool:	MC Registry or client medical records maintained by each program/site
Method of measurement:	The numerator can be generated by summing the clients documented as having received MC within the reporting period in MC Registries or clients' medical records maintained by programs. <u>Explanation:</u> While services must be provided within the context of the minimum MC package, only males who have received a circumcision surgery in accordance with the WHO/UNAIDS/Jhpiego <i>Manual for Male Circumcision Under Local Anesthesia</i>¹ and per national standards by funded programs/sites in the reporting period meet the definition for the numerator. Other services within the MC minimum package (i.e. Testing, Behavioral Change, counseling, or training of health professionals) should not be counted here, but may be captured under separate but appropriate indicators found in this document. PEPFAR does not provide funding to perform male circumcision under general anesthesia, and cases of MC under general anesthesia should not be paid for by PEPFAR and should not be counted in the indicator. Children may receive PEPFAR-funded MC as long as the procedure is performed using local anesthesia and in accordance with the WHO/UNAIDS/Jhpiego <i>Manual for Male Circumcision Under Local Anesthesia</i>.¹ MC using local anesthesia should be deferred if the maturity level of the child precludes use of local anesthesia. Programs should focus on compiling data for the numerator from MC Registers or client medical records maintained by funded programs/sites. A program site is a fixed or mobile facility that is able to provide all components of the minimum package of MC for HIV prevention services. The MC minimum package of services must include elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive HIV prevention messages/services that include: on-site pre-operative HIV counseling and testing (offer of); active exclusion of symptomatic STIs and syndromic treatment when indicated; post-operative wound care and abstinence instructions; age-appropriate counseling on risk reduction, reducing number and concurrency of sexual partners, and delaying/abstaining from sex; and provision and promotion of correct and consistent use of male and/or female condoms. It is anticipated that some programs may establish formal referral relationships with voluntary counseling and testing (VCT) services to provide the HIV testing components of the MC minimum package of services. In these cases, a repeat HIV test 'on-site' may not be necessary, if the MC program and VCT service have agreed upon what constitutes 'certifiable results.' Though it is not possible to mandate a specific length of time before the MC surgery that an HIV test must have been done, it is suggested that the HIV test be done within the prior 3 months. Clients who present without a 'certifiable result' and wishing to defer HIV testing are not able to self-report their result. Such clients should be counted in the 'unknown/refused HIV test' recommended disaggregation category. Clients circumcised in a fixed/permanent location, such as a hospital or clinic, should be counted in the 'fixed/permanent location' recommended disaggregation category. Those circumcised in a school, tent, mobile facility, or in any location intended for use as another purpose but temporarily established for MC, should be counted in the 'temporary (including mobile) location' recommended disaggregation category.

Interpretation:	Programs are required to report on the actual number of males circumcised in accordance with the WHO/UNAIDS/Jhpiego <i>Manual for Male Circumcision Under Local Anesthesia</i>¹ so that the overall uptake and delivery of the PEPFAR-funded MC minimum services package in the country can be monitored, outcomes evaluated, and impact of MC on HIV incidence at a population level can be modeled. Comparing current and previous values may indicate newly implemented service delivery or changes in supply or demand volume. When the number of male circumcisions is disaggregated by age and HIV status, it will be possible to adjust inputs used in models to determine impact of male circumcision programs on HIV incidence. Disaggregation by age may be particularly helpful in determining whether age-specific communication strategies are working to create demand. Disaggregation by service delivery location/setting may allow for evaluation of resource allocations. Non-PEPFAR funded providers also performing MCs within the reporting period will not be captured by this indicator, and any broader evaluations of population-level uptake will need to be interpreted accordingly.
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Indicator #P6.1.D	3.1.1-64 Number of persons provided with post-exposure prophylaxis (PEP)
Type of Indicator:	Direct
Numerator:	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.
Denominator:	None
Disaggregation:	By exposure type: Occupational, Rape/Sexual Assault Victims, Other Non-Occupational
Purpose:	A key consensus at the 2005 Joint International Labor Organization/World Health Organization Technical Meeting for the Development of Policy and Guidelines regarding occupational and non-occupational HIV-PEP was that HIV-PEP must be part of comprehensive HIV prevention, occupational health, and post-rape care service policies (UNAIDS). PEPFAR considers availability of PEP to be a cross-cutting issue that addresses concerns in multiple program areas. The data that will be collected through this indicator provides information to answer questions around prevention, program quality, human resources for health, gender, and overall health system strengthening. PEPFAR HQ will use this data to report to Congress, other U.S., and international stakeholders, to monitor coverage of PEP services and to track progress of PEP scale-up over time.
Applicability:	All countries with PEPFAR-funded partners providing PEP services for either occupational or non-occupational purposes
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program monitoring tools and reports
Method of measurement:	The indicator can be generated by counting the number of individuals receiving PEP for occupational and non-occupational purposes. Individuals should be counted only one (1) time, not incidence. This indicator should not include infants who receive neonatal prophylaxis. <u>Explanation:</u> Countries should regularly update their program records on the availability of PEP services in health facilities, and supplement these data with those obtained through a health facility survey or census every few years. <u>PEP services for occupational exposure include:</u> PEP services include a comprehensive package of services for occupationally exposed health care workers and patients. Individuals should be counted only if they have received PEP drugs (in accordance with international or national protocols). <u>PEP services for non-occupational exposure include:</u> PEP service delivery for sexual violence or other non-occupational includes PEP services as part of a larger, comprehensive package of services for sexual violence victims. Individuals should be counted only if they have received PEP drugs (in accordance with international or national protocols).
Interpretation:	This indicator does not intend to capture the type and quality of PEP services provided. PEP services may include first AID, counselling, testing, provision of ARVs, medical care, trauma counselling, linkages with police, and other follow-up and support. Simple monitoring of PEP availability through program records does not ensure that <i>all</i> PEP-related services are <i>adequately</i> provided to those who need them.

	It is anticipated that access to PEP for sexual violence victims will be low initially. This number will remain low in countries where HIV prevalence is relatively low and incidence of sexual violence is low. However, in those countries where sexual violence and HIV are prevalent, percentages are expected to increase.
Additional information:	- Occupational and Non-occupational Post-exposure Prophylaxis for HIV Infection (HIV-PEP), Joint ILO/WHO Technical Meeting for the Development of Policy and Guidelines: Summary Report (2005) http://www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/Techpolicies/HIV_post_Technical_policies.asp - Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection http://www.who.int/hiv/pub/guidelines/PEP/en/index.html - Refer to the PEPFAR Palliative Care Indicator TWG with further inquiries

Indicator #P7.1.D	3.1.1-65 Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions
Type of Indicator:	Direct
Numerator:	Number of People Living with HIV reached with a minimum package of PwP interventions
Denominator	Total estimated number of PLHIV in the catchment area*
Disaggregation	By Setting: Number reached in a clinic/facility-based setting; Number reached in a community/home-based setting
Purpose:	Prevention efforts with HIV positive persons (PwP) are part of a comprehensive prevention strategy and include both behavioral and biomedical interventions. The purpose of this indicator is to measure how well clinic/facility-based and community-based programs are reaching PLHIV with a minimum package of prevention interventions and services that includes evidenced based behavioral and biomedical interventions designed to protect the health of the infected person and reduce the spread of HIV to their sex partners and children. Headquarter staff can use this information to plan and make decisions on how well PLHIV are being reached with PwP interventions. If a small percentage of the intended target population is being reached, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who deliver the minimum package of PwP interventions to HIV positive persons (and their partners) in either clinic/facility or community/home settings should report on this indicator.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	The numerator can be generated by counting the number of PLHIV who are reached with a minimum package of PwP interventions (see definition below). The sexual partner(s) or family members of a PLHIV may also receive a service as part of the PwP intervention. While these services may contribute to the minimum standards that are required to count the PLHIV, only the PLHIV should be counted under this indicator. Do not additionally count the partner or family member. Note: The service provided to the partner or family member may meet the defined criteria for another indicator and (if so) should be counted there, i.e. Testing and Counseling (#P11.1.D), CARE (#C1.1.D), or Early Infant Diagnosis (#C4.1.D). <u>Explanation of Numerator:</u> Minimum Package of PwP interventions required for the indicator: In order to count under this indicator, PLHIV must have received <u>at last visit</u> (in a clinic/facility-based or community/home-based program) the following interventions that constitute the minimum package of PwP: Assessment of sexual activity and provision of condoms (and lubricant) and risk reduction counseling (if indicated)

- Assessment of partner status and provision of partner testing or referral for partner testing
- Assessment for STIs and (if indicated) provision of or referral for STI treatment and partner treatment
- Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services
- Assessment of adherence and (if indicated) support or referral for adherence counseling
- Assessment of need and (if indicated) refer or enroll PLHIV in community-based program such as home-based care, support groups, post-test-clubs, etc.

Description: All clinic/facility-based and community/home-based programs serving PLHIV should include a package of behavioral and biomedical prevention interventions that are consistent with the guidelines outlined in the PWP technical considerations. These interventions should be provided at each client encounter and delivered either onsite or (where specifically noted above) through a referral program in which the client is enrolled. Partners using referral sites must confirm that they are accessible and providing the referral service. All PLHIV should be provided with an adequate supply of condoms (and lubricant) and risk reduction counseling which addresses condom use, partner reduction, and alcohol reduction. All negative or unknown status partners of PLHIV should be tested at least every year; discordant couples should be identified and provided with appropriate prevention counseling and services. Regular screening and treatment for STIs should be part of routine care and prevention for PLHIV, and STI treatment for partners of PLHIV should also be provided. Provision of family planning counseling, contraceptive methods or safer pregnancy counseling should be provided to HIV-positive women and their partners as part of routine care to reduce unintended pregnancy and prevent maternal-to-child transmission. Adherence to ARVs and all medications is also important for maintaining low viral loads and reducing risk of transmission. Finally, all interventions delivered through clinics/facilities should be reinforced through community-based programs, and linkages and referrals from community programs to clinics should be incorporated into all community programs serving PLHIV.

Explanation of Denominator:

Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For PLHIV, depending on the target sites, there may be registration available at the local health facility. Alternatively, PLHIV estimates for subdistricts/districts/regions/the nation can be used if available.

The percent coverage can be determined if both the numerator and denominator are included. Country teams and partners are encouraged to consider ways to estimate denominators, using similar methods used in estimating targets.

Note on Disaggregation:

Given that the same individual may be reached with services in both a facility and community based setting, when aggregating this indicator across multiple partners,

	country teams may choose to allow the double counting, in which case the “Number reached in community” + “Number reached in facility” ≥ “Total number reached.”
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received a minimum package of PwP interventions according to the PwP technical considerations. The indicator will help the country teams to determine reach (if no denominator) and coverage (if denominator is also collected) to help country programs understand the extent and reach of evidence-based programs for further expansion.

Indicator #P8.1.D	3.1.1-66 Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
Type of Indicator:	Direct
Numerator:	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required
Denominator:	Total number of intended target population in the catchment area *Recommended at partner level only
Disaggregation:	By Sex: Male, Female By Age: 10-14, 15+
Purpose:	Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity (including intended number of sessions) to the appropriate populations is an important component of comprehensive HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended audience with HIV prevention programming. This information can be used to plan and make decisions on how well a certain audience is being reached with individual and/or small group level interventions. If a small percentage of the intended audience is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended audience is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level prevention interventions that seek to modify behaviors that lead to HIV transmission among general populations, including adult and youth (both in and out of school youth).
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	<u>This indicator is intended to capture programs targeting general populations.</u> Programs that specifically target MARP or PLWHA populations should not be counted under this here. Instead count these populations under indicators #P7.1.D and #P8.1.D. <u>Explanation of Numerator</u> The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached with and complete the defined prevention intervention. <i>This indicator only counts those interventions at the individual and/or small group level. Individual and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in.</i>

In order to be counted, an individual should complete the intended number of sessions that were implemented with fidelity to the intervention.

Number reached: Number of individuals in the target population who are reached with and complete individual and/or small group level HIV Prevention interventions that are based on evidence and/or meet the minimum standards required.

Intended Target Population: The specific target population around which a prevention intervention was intentionally designed. Populations to be counted in this indicator are general population adult and/or youth, including both in school and out of school youth. For this indicator, populations that participate in a variety of behavioral risks could be counted, including but not limited to the following illustrative examples: individuals who engage in: transactional sex (giving or receiving a gift in exchange for sex); sex under the influence of alcohol; other behaviors that could place them at risk of transmission.

Only individuals representing the specific 'intended audience' will count under this indicator. For example: If a program activity is designed to target youth (ages 10-15) and individuals who are much older or much younger than the intended target population participate in the activity, then these individuals should not be counted. Only the 10-15 year olds for which the program was designed should be counted.

Individual-level interventions (ILI): Interventions that are provided to one individual at a time (e.g., individual counseling). The intervention assists clients in making plans for individual behavior change and ongoing appraisals of their own behavior. Counseling associated with testing and counseling should not be counted here.

Small group level interventions (GLI): Interventions that are delivered in small group setting (less than 25 people) and that assist clients in making plans for behavior change and appraisals of their own behavior. Small group can include a family or couple.

Evidence-based interventions: Interventions based on the country's epidemic, the drivers of that epidemic, and the most current understanding of behavioral and/or social science. Evidence based HIV behavioral interventions have been rigorously evaluated and have been shown to have significant and positive evidence of efficacy (e.g. elimination or reduction of risky sexual or drug taking behaviors). These interventions are considered to be scientifically sound, provide sufficient evidence of efficacy in other contexts and/or target populations, and address HIV prevention needs of the communities by targeting the specific target population.

Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required.

Minimum Standards Required: In the absence of evidence-based interventions, other interventions that could be considered for implementation are those who meet the minimum standards required. These interventions are based on sound behavioral science theory and do have some empirical evidence in the form of being based on formative assessment results. They can also be based on a past successful program. All programs should use process monitoring data to continually gage the appropriateness of the intervention and plan to collect outcome monitoring data to determine effectiveness.

	In order to count persons reached, the interventions must: – have a clearly defined audience – have clearly defined goals and objectives – be based on sound behavioral and social science theory – be focused on reducing specific risk behaviors – have activities that address the targeted risk behaviors – employ instructionally sound teaching methods – provide opportunities’ to practice relevant risk reduction skills <u>Intended number of sessions:</u> The number of sessions defined in the program description and as prescribed in the intervention. One component linked to the effectiveness of curriculum-based programs is completing the intended number of sessions of that curriculum. If fewer sessions are conducted, then that program is not following one of the criteria for effective curriculum based sessions. Activity narratives or partner plans should define the number of sessions that are planned and how many (percent of) sessions that must be attended/completed by an individual in order to “count.” This may be done activity by activity with oversight from PEPFAR in-country team or the in-country team may wish to set a standard for all partners working in the area of prevention. <u>Comprehensive Prevention Programs:</u> Implementing a comprehensive prevention program at the country level involves multiple components such as setting epidemiologically sound priorities, developing a strategic prevention portfolio, employing effective program models, supporting a coordinated and sustainable national response, establishing quality assurance/monitoring/evaluation mechanisms, and expanding and strengthening PEPFAR prevention staff. Comprehensive prevention programs include interventions at multiple levels (e.g., mass media, community-based, workplace, small group, and individual) as well as providing a range of messages that are appropriate for the country’s epidemic and the specific target group. Prevention programs should appropriately link to services such as male circumcision and counseling and testing, address stigma and discrimination, and increase awareness of social norms that affect behaviors. Effective ABC messages are also a goal. The ABC paradigm includes abstinence, delay of sexual debut, mutual faithfulness, partner reduction, and correct and consistent use of condoms by those whose behavior places them at risk for transmitting or becoming infected with HIV. The most appropriate mix of programs and messages will depend on the country’s epidemic, what populations are being focused on, the circumstances they face, and behaviors within those populations that are targeted for change. Comprehensive prevention programs must be based on evidence and/or meet the minimum standards required. <u>Explanation of Denominator (recommended at partner level):</u> Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. For the general population, depending on the target sites, there may be a registration available of individuals between the ages of 25 and 49. Population estimates for sub-districts/districts/regions can also be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
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Interpretation:	This indicator provides information on the total number of unduplicated individuals that received individual-level and/or small-group level interventions.
Additional Information	Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries.

Indicator #P8.2.D	3.1.1-67 Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are <u>primarily focused on abstinence and/or being faithful</u>, and are based on evidence and/or meet the minimum standards required
Type of Indicator:	Direct
Numerator:	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required
Denominator:	Total number of intended target population in the catchment area *Recommended at partner level only
Disaggregation:	By Sex: Male, Female By Age: 10-14, 15+
Purpose:	This information will be used to report to congress on AB only interventions.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level HIV prevention interventions that seek to modify behaviors that lead to HIV transmission <u>through programs focused primarily on AB interventions</u> .
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	<u>Explanation of Numerator</u> The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached primarily through AB prevention intervention. <i>Primarily focused:</i> The messages and content of the activities spend the <i>majority</i> of their time discussing; increasing individual and group's self-risk assessments; building the skills; and other supportive behavioral, cognitive and social components to increase the AB behaviors. <i>Abstinence and/or being faithful:</i> AB interventions can include programs, services, and messages which encourage sexual abstinence, delay of sexual debut and secondary abstinence, mutual fidelity, mutual knowledge of HIV status, and social and gender norms which promote mutual respect and open communication about sexuality. AB interventions can also include programs, services, and messages which discourage multiple and/or concurrent partnerships, cross-generational and transactional sex, sexual violence, stigma, and other harmful gender norms and practices. AB interventions targeting youth should support skills-based sexuality and AIDS education as well as involve parents and guardians to improve communication with children and parenting skills. <i>See Indicator #P8.1.D for definitions of additional terms required to define this indicator:</i> <i>Comprehensive Prevention Programs</i> <i>Intended Target Population</i> <i>Small group level interventions (GLI)</i> <i>Evidence-based interventions</i> <i>Number reached</i> <i>Minimum Standards Required</i> <i>Intended number of sessions</i>

	<u>Explanation of Denominator (recommended at partner level):</u> <i>Catchment area:</i> Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services provided. Population estimates for subdistricts/districts/regions can also be used to help define target populations if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received individual-level and/or small-group level interventions. These interventions are based on evidence and/or meet the required minimum standards. The information collected will allow the country and the PEPFAR to assess any changes in risk behaviors as a result of the implemented interventions. The information will also help the country to understand the efficacy and effectiveness of evidence-based interventions and help in further expansion of similar interventions.
Additional Information	Refer to the PEPFAR Behavior Based Prevention Indicator TWG with further inquiries.

Indicator #P8.3.D	3.1.1-68 Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required
Type of Indicator:	Direct
Numerator:	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required
Denominator:	Total estimated number of MARP in the catchment area* *Recommended at partner level only
Disaggregation:	Essential/reported: By MARP type: CSW, IDU, MSM, Other Vulnerable Populations Essential/not reported: By sex: Male/Female
Purpose:	Individual and small-group level prevention interventions have been shown to be effective in reducing HIV transmission risk behaviors. Delivering these interventions with fidelity to the appropriate populations is an important component of combination HIV prevention strategies. It is important to know how many people complete an intervention in order to monitor how well programs are reaching the intended target population with HIV prevention programming. Headquarter staff can use this information to plan and make decisions on how well a certain target population is being reached with individual and/or small group level interventions. If a small percentage of the intended target population is being reached with either one intervention, then it would be recommended that activities are adjusted to improve reach. If a large percentage of the intended target population is being reached, then headquarter staff would want to take these lessons learned and disseminate them to other countries. The country can use the information to improve upon the quality of the program as well as scale-up successful models.
Applicability:	All countries with PEPFAR-funded partners who implement individual and/or small group level prevention interventions that seek to modify behaviors that lead to HIV transmission should report on this indicator.
Data collection frequency:	Data should be collected continuously at the organization level. Data should be aggregated in time for PEPFAR annual reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Data can be obtained from program monitoring tools.
Method of measurement:	<u>Explanation of Numerator:</u> The numerator can be generated by counting the number of de-duplicated individuals from an activity defined target population who are reached with and complete a prevention intervention designed for the intended MARP. This indicator only counts those interventions at the individual and/or small group level. Individual and small group level interventions are components of a comprehensive program but are not by themselves defined as a comprehensive program. Partners do not have to implement comprehensive prevention programs to utilize this indicator, but should work with other partners and stakeholders to ensure that comprehensive prevention programs are implemented in the communities that they work in. <u>Additional Disaggregation – Other Vulnerable Populations</u> Please note, there may be other populations that have increased vulnerability to HIV due to

a combination of behavioral, social, or environmental factors. Groups that should be counted in the category of Other Vulnerable Populations include:

- Military and other uniformed services
- Incarcerated persons
- Mobile populations (e.g. migrant workers, truck drivers)
- Clients of sex workers
- Non-injecting drug users

Core Package of Services for MARPS: Based on the epidemiologic profile for each country the aim of the country team should be to scale-up a combination of targeted interventions adapted for different sub-groups especially vulnerable to HIV. These interventions could include but are not limited to:

- Community-based peer outreach
- Voluntary testing and counseling (*If providing these services, also use indicator #P11.1.D*)
- Behavior change programs including targeted condom distribution for those who practice high-risk sexual behavior
- Diagnosis and treatment of STIs (*If providing these services, also use indicator #C2.1.D*)
- Referrals to a range of substance abuse and treatment services
- Linkages through referral networks with other health services
- Programs to prevent alcohol/drug-related sexual risk-taking behaviors and HIV transmission
- Vocational skills training or other income-generation activities
- Drop-in centers for creation of “safe space”

Service models (e.g. VCT) developed for a general population may need to be adapted to reach, engage and meet the needs of most-at-risk populations. The country team is encouraged to incorporate tailored or innovative approaches that are likely to increase access and remove barriers to services for these populations. Use of qualitative methods to guide these adaptations has proven to be an effective strategy.

The network model encourages and supports linkages to care and treatment as well. Keeping linkages in mind as care and treatment programs are planned will help achieve the overall PEPFAR goals and assist MARP populations.

Commercial Sex Workers (CSW): Effective CSW prevention programming should:

- Ensure participation of target group in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both clients and regular non-paying partners/boyfriends/husbands
- Ensure consistent availability of quality male and female condoms and lubricant
- Ensure availability of comprehensive health care services with special emphasis to quality VCT, STI and FP services and provision of or linkages to HIV treatment and care services (*If actually providing these services, also use indicators #P11.1.D and C2.1.D*)
- Integrate violence reduction (both social and structural) in prostitution settings
- Link with relevant social welfare services for the target group and their families
- Provide vocational training (*If vocational training is HIV/health related, then also use indicator #H2.3.D*)

Men Who Have Sex With Men (MSM): Effective MSM prevention programming should:

- Ensure participation of MSM in the development, implementation and monitoring of prevention programs
- Promote consistent and proper use of condoms to achieve >90% use with both regular and non-regular partners
- Ensure consistent availability of quality male condoms and lubricant
- Ensure availability of comprehensive health care services with special emphasis to quality VCT and STI services and provision of or linkages to HIV treatment and care services. *(If actually providing these services, also use indicators #P11.1.D and #C2.1.D)*

Injection Drug Users: Generally speaking, PEPFAR promotes three approaches to HIV prevention for injecting drug users:

1. Tailoring HIV prevention programs to injecting drug users: these programs should rely on tools, guidelines and evidence-based interventions designed to reduce risk of HIV transmission. A comprehensive program should include, information and education, community based outreach, risk reduction counseling, targeted condom distribution activities and substance abuse treatment, and to address HIV prevention and risk reduction. These services should be provided in multiple venues to reach this hard to reach population and engage them in activities to enable them to eliminate/reduce risks for acquiring and or transmitting HIV
2. Offering HIV-infected drug users a comprehensive program to reduce their risk of transmission: a comprehensive multi-component HIV/AIDS treatment program for injecting drug users should promote recovery through confidential HIV counseling and testing, ART, palliative care, STI and tuberculosis treatment, substance abuse treatment (including medication-assisted therapies) and transitional services between treatment facilities and the community.
3. Supporting substance abuse programs as an HIV prevention measure: these programs may include behavioral models or medication-assisted treatment (e.g. using methadone or buprenorphine), or a combination of the two, and should also include case management and counseling services. Medication-assisted treatment programs have been demonstrated to be an effective HIV prevention strategy. Medication assisted therapy program should be an access point for IDUs and the program should refer and link to ARV treatment programs, PMTCT for female IDUs and a range of other prevention services. *(If actually providing opioid substitution therapy, also use indicator #P4.1.D)*

See Indicator #P8.1.D for definitions of additional terms required to define this indicator:

Comprehensive Prevention Programs

Intended Target Population

Small group level interventions (GLI)

Evidence-based interventions

Number reached

Minimum Standards Required

Intended number of sessions

Explanation of Denominator (recommended at partner level):

Catchment area: Geographic region from which persons come to receive HIV prevention services, or from which persons are being recruited into HIV prevention services. The size and population of this area can vary, depending on organization or agency and the services

	provided. MARP estimates for subdistricts/districts/regions can be used if available. The percent coverage can be determined if both the numerator and denominator are included. Country teams can encourage their partners to consider ways to estimate denominators, using similar methods used in estimating targets.
Interpretation:	This indicator provides information on the total number of unduplicated individuals that received and completed individual-level and/or small-group level interventions. These interventions are based on evidence and/or meet the required minimum standards. The indicator will help the country teams to determine reach (if no denominator) and coverage (if denominator is also collected) to help country programs understand the extent and reach of evidence-based programs for further expansion.

Indicator #C1.1.D	3.1.1-69 Number of eligible adults and children provided with a minimum of one care service																
Type of Indicator:	Direct																
Numerator:	Number of adults and children provided with a minimum of one care service																
Denominator:	N/A																
Disaggregation:	<table><tr><td>Essential/reported</td><td>Males</td></tr><tr><td>Essential/reported</td><td>Females</td></tr><tr><td>Essential/reported</td><td><18 years of age</td></tr><tr><td>Essential/reported</td><td>18+ years of age</td></tr><tr><td>Recommended</td><td><1</td></tr><tr><td>Recommended</td><td><5</td></tr><tr><td>Recommended</td><td><15</td></tr></table> Age represents an individual's age at the end of the reporting period or when last provided with a support service.			Essential/reported	Males	Essential/reported	Females	Essential/reported	<18 years of age	Essential/reported	18+ years of age	Recommended	<1	Recommended	<5	Recommended	<15
Essential/reported	Males																
Essential/reported	Females																
Essential/reported	<18 years of age																
Essential/reported	18+ years of age																
Recommended	<1																
Recommended	<5																
Recommended	<15																
Purpose:	PEPFAR has a legislative 5-year goal to care for 12 million individuals, including care services to 5 million children orphaned or made vulnerable by HIV. PEPFAR recognizes that individuals, families, and communities are being affected by HIV in ways that may hinder the medical outcomes of HIV-positive persons as well as the emotional and physical development of children orphaned or made vulnerable by HIV. A variety of services are supported through PEPFAR to mitigate these effects in order to improve health outcomes for HIV positive, improve the developmental growth of children, and optimize the quality of life of adults and children living with and affected by HIV This indicator measures the number of individuals receiving care services through PEPFAR. Data collected through this indicator will inform country programs and PEPFAR about the scale-up of services for individuals affected by HIV. Data collected from this indicator can inform program planning, budget allocations, and will be used to report against the legislative 5-year goal of 12 million individuals. The age disaggregation (<18) will be used to report on the goal of 5 million children who are orphaned or made vulnerable due to HIV.																
Applicability:	All countries with PEPFAR-funded partners providing services that traditionally fell under the Care and Support or OVC technical program areas. (see appendix 2 for menu of support services and clinical services)																
Data collection frequency:	Data should be collected continuously at facility and/or community/home-based sites. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review																
Measurement tool:	Registers/databases, client records and registers, or other program monitoring tools. Programs may need to modify the revised WHO Pre-ART/ART registers to capture this data.																
Method of measurement:	The numerator is generated by counting the number of eligible individuals who received at least one care service from facilities and/or community/home-based organizations. This is the number of unique individuals receiving care services. Definitions: PEPFAR CARE programs include <u>support</u>, <u>preventative</u>, and <u>clinical</u> services <u>Clinical Services</u> – Include a broad range of services related to the specific clinical needs of HIV-positive persons. Clinical services may be provided in facilities, the community, or in																

	the home, and may include both <i>assessment</i> of the need for interventions (for example assessing pain, clinical staging, and eligibility for Cotrimoxizole, or screening for tuberculosis) or provision of needed interventions. These services are further defined under the CARE indicator for Clinical Services for HIV-positive. See appendix 2 for the full menu of clinical services. <u>Individuals eligible for clinical services:</u> People living with HIV/AIDS (PLWHA), including pregnant women <u>Preventive Services</u> - Include a range of services related to the prevention of the transmission or acquisition of HIV. Services may include both <i>assessment</i> of risk and need for interventions or provision of needed interventions. _ <u>Support Services</u> – Include a broad range of services, which provide social, psychological, or spiritual support and are appropriate for all persons who are affected by HIV, including people living with HIV/AIDS (PLWHA). Support services fall into these broad categories: Psychological, spiritual, preventive, food support*, shelter, protection, access to health care, education/vocational training, and economic strengthening. See appendix 2 for the full menu of support related services. <u>Individuals eligible for preventive and support services:</u>
	-Adults and children living with HIV (PLWHA), including pregnant women-Family members, caregivers, or other household members living with or caring for an HIV-positive individual or an OVC -Children made vulnerable due to HIV (<18 years old) including children who have lost one or both parents to AIDS, who live in households made increasingly vulnerable because of HIV/AIDS. In high prevalence communities, all children may be affected due to break down in community support, loss of teachers, or other social support as a result of HIV epidemic.-Infants born to HIV-positive mothers
	To count under this indicator, individuals must receive a minimum of one service. However, PEPFAR programs should seek to provide a comprehensive set of support and clinical services appropriately tailored to the status of the individual or family. This comprehensive set of services should include linkages to partners providing other types of services as indicated. For HIV-infected persons, programs should ensure that patients receive services through the full continuum of care, which extends specifically to clinical services (see indicator #C2.1.D) and eventually to anti-retroviral therapy (see indicator #T1.1.D). The aggregated total for this indicator is not simply the sum of the individuals served by all partners. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total. Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary reporting level. <i>For example: individuals may receive services from different partners and still be counted at the partner level (i.e. social service from partner A and psychological services from partner B), individuals should only be reported once at the summary program level.</i> *Food Support may also fall under clinical support when provided as therapy for clinically malnourished HIV-positive clients. See indicator #C2.3.D
Interpretation:	This is a high-level indicator that provides the total number of all individuals receiving care

	services through PEPFAR from facilities and/or community/home-based organizations. While an individual must receive at least one care service to be counted, this indicator does not articulate what type of service was provided, or where it was provided. However, subsets of this high-level indicator provide more specificity regarding types of populations and services received (For example, see indicators #C2.2.D, #C2.3.D, and #C2.4.D) This indicator does not currently provide measures of coverage, nor does it measure quality or effectiveness of services.
Additional Information:	Partially harmonized with Care and support (HIV-CS2), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009
	http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf - WHO Pre-ART/ART registers http://www.who.int/hiv/pub/imai/imai_registers_preart.pdf - Refer to the PEPFAR Care/OVC Indicator TWGs with further inquiries

Indicator #C2.1.D	3.1.1-71 Number of HIV-positive adults and children receiving a minimum of one clinical service		
Type of Indicator:	Direct		
Numerator:	Number of HIV-positive individuals receiving a minimum of one clinical service		
Denominator:	N/A		
Disaggregation:	Essential/reported	Males	
	Essential/reported	Females	
	Essential/reported	<15 years of age	
	Essential/reported	15+ years of age	
	Recommended	<1, <5, years of age	
Age represents an individual's age at the end of the reporting period or when last provided with a clinical care service.			
Purpose:	People living with HIV/AIDS (PLWHA) should receive a comprehensive package of services in order to improve quality of life, extend life and delay the need for ART. The goal should be to provide services in each of 5 domains described in PEPFAR care and support guidance (clinical, psychological, spiritual, social, and prevention) and to provide these services using a holistic approach, from the time of HIV diagnosis. While the goal of programs should be to ensure a comprehensive package of care and support services, clinical services are essential for all HIV-positive individuals. All HIV-positive individuals should receive clinical services, including for example <i>assessment</i> for symptoms of tuberculosis or need for OI prophylaxis or ART. To be counted for this indicator, HIV-positive individuals must receive a minimum of one clinical service. This indicator attempts to track progress in providing care and support services to all HIV-positive individuals. Please refer to Appendix 2 for a list of services. This indicator attempts to measure how many HIV-positive individuals received care and support services, defined by receipt of at least one clinical service. Data collected through this indicator will inform country programs and PEPFAR about scale up of care services for HIV-positive individuals. With these data, HQ can provide additional support and technical assistance to countries in strengthening network systems that assure access and use of care services by HIV-positive individuals.		
Applicability:	All countries with PEPFAR-funded partners providing clinical services, including partners providing home-based care services. Partners who are not directly providing clinical services as defined in appendix 2 should not report on this indicator. Partners who refer patients but do not actually provide clinical services should not report on this indicator.		
Data collection frequency:	Data should be collected continuously at facility and community/home-based sites. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review.		
Measurement tool:	Facility registers/databases, patient/client records and registers, or other program monitoring tools.		
Method of measurement:	The numerator can be generated by counting the number of HIV positive adults and children who received at least one clinical service. The numerator should equal the number of adults and children with HIV infection who have received one care service and specifically are receiving at least one clinical service during the reporting period. Individuals may receive care and support services from different partners. For example, a		

	patient may receive a clinical service from partner A and social services from partner B. In this case the patient will be counted under indicator #C1.1.D as well as this indicator (#C2.1.D). However, if an HIV-positive patient receives a care service that does not include a clinical service, he/she may be counted under indicator #C1.1.D only and may <u>not</u> be counted under this indicator. The aggregated total for this indicator is not simply the sum of the individuals served by all partners. Overlap of services provided by facility-based care and support and community/home-based care and support partners must be adjusted for so that individuals are counted only once in the aggregated total. <u>Clinical services</u> may be provided in facilities, the community, or in the home, and may include both <i>assessment</i> of the need for interventions (for example assessing pain, clinical staging, eligibility for Cotrimoxizole, or screening for tuberculosis) and <i>provision</i> of needed interventions: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, nutritional rehabilitation for malnourished PLWHA. While partners may be supported to provide services only in a single domain (for example only social support), individuals receiving that support should be linked to other providers who provide clinical services to meet the criteria to count an individual as receiving one clinical service. Please refer to appendix 2 for a list of clinical services. While a minimum of one clinical service is sufficient to count an HIV-positive individual for this indicator, PEPFAR requires that programs strive to provide comprehensive care to all HIV-positive individuals by providing other needed services (clinical and support services) either directly or through referral. Individuals who receive services from more than one partner or provider should be de-duplicated at the program summary level.		
Interpretation:	This indicator is the total number of unduplicated HIV-positive individuals receiving a minimum of one clinical service from facilities and/or community/home-based organizations. While an individual must receive at least one clinical care service to be counted, this indicator does not articulate what type of clinical service was provided, or where it was provided, nor does it capture other care and support services (from the other domains of care (i.e. support services) that may have been provided. Data from this indicator will not assess linkages within or between care and support sites. This indicator allows country programs and PEPFAR Headquarters to monitor trends and coverage of at least one clinical service to HIV-positive persons. The specific clinical or other care and support services an individual may require will vary according to several factors including stage of disease, treatment, service availability, and cost. This indicator does not measure quality or effectiveness of services.		
Additional Information	Refer to the PEPFAR Care/OVC Indicator TWGs with further inquiries.		
Indicator #C2.2.D	3.1.1-72 <u>Subset of indicator #C2.1.D</u> Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis		
Type of Indicator:	Direct		
Numerator:	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis		
Denominator	<u>Program coverage</u>: Use numerator from Indicator C2.1.D <u>Population coverage</u>: Number of HIV-positive individuals who are eligible for CTX, (according to national guidelines)		
Disaggregation:	Essential/not reported	<15, 15+, years of age	

	<i>Recommended</i>	<1, <5
	<i>Recommended</i>	<i>Males</i>
	<i>Recommended</i>	<i>Females</i>
Age represents an individual's age at the end of the reporting period or when last provided with CTX.		
Purpose:	CTX prophylaxis is a simple and cost-effective intervention that reduces the risk of opportunistic infections (OIs) and mortality in HIV-positive children and adults. WHO recommends administration of CTX for the following groups: adults with HIV infection, including pregnant women, children with HIV infection, and infants exposed to HIV. The WHO guidelines offer countries a choice of whether to provide CTX broadly or according to disease stage. This indicator is important to country teams and HQ for several reasons including: • Assesses scale-up and coverage of CTX prophylaxis • Identifies gaps in services to improve scale-up and coverage • Provides data to assess quality of care • Focuses on a primary intervention for HIV-positive infants, children, and adults • Informs program planning and budget allocations to improve utilizations of resources to focus on this essential intervention	
Applicability:	All countries with PEPFAR-funded partners providing clinical services to HIV positive individuals should report on this indicator, including all partners reporting on indicator #C2.1.D	
Data collection frequency:	Data should be collected continuously at the facility level (or community level). Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review	
Measurement tool:	Program monitoring tools, including Pre-Art and ART registers and electronic databases that routinely record provision of CTX, including pharmacy records	
Method of measurement:	The numerator can be generated by counting the number of HIV-positive individuals receiving CTX prophylaxis at some point during the reporting period. <u>Explanation of Numerator</u> Individuals should be considered to be “receiving” CTX prophylaxis if CTX has been prescribed and obtained by the patient (provided by a program or procured by the patient). The indicator is not meant to account for short term lapses in adherence or short term stock outs. If individuals are served by more than one program that might provide CTX prophylaxis, the figure should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period. Countries should focus on compiling data for the numerator from patient registers at facilities. Where patient level data are not available, countries may develop program or facility level estimates of coverage with CTX and apply these estimates to the total number of individuals receiving care and support services through those programs or facilities. HIV-positive individuals receiving CTX in both the private sector and the public sector should be included in the numerator where data for both are available. Provision of Cotrimoxizole is one of the key services included under “clinical” services. [The information will be considered in the context of the national policy on CTX in the country, the total numbers of HIV-positive individuals in the country, WHO guidelines, and the numbers of HIV-positive individuals receiving HIV care services.]	
Interpretation:	Countries may be at different phases in developing national guidelines on provision of CTX	

	for HIV-positive individuals. The figure of individuals served by more than one program should be adjusted as needed so that the numerator represents only unique individuals receiving CTX within the reporting period, which would be impossible without unique IDs and electronic monitoring systems. Although countries may not have a system in place yet to collect and report coverage of CTX among HIV-positive individuals, the goal should be to develop such a system. This indicator permits monitoring trends in the numbers and proportion of HIV-positive persons receiving CTX prophylaxis. Since countries have different guidelines for provision of CTX to HIV-positive individuals, cross-country comparisons of aggregate estimates and proportions must be interpreted with caution and with reference to eligibility criteria. In addition to tracking the numbers of persons on prophylaxis, this indicator can be interpreted as a proportion, or measure of coverage, using various denominators as appropriate. Coverage can be considered using different denominators, for example the proportion of HIV-positive persons in care (receiving at least one clinical service) receiving CTX, the proportion of the estimated number of HIV-positive persons in the country (or area receiving PEPFAR support) receiving CTX, or the proportion of HIV-positive individuals who are eligible for CTX, (according to national guidelines) who are receiving CTX. This indicator attempts to track progress in scale-up of CTX to HIV-positive individuals in a country. The indicator does not attempt to capture interruptions in drug availability or patient adherence to prescribed therapy. The reports will need to be interpreted in the context of national policies (some countries recommend CTX for all HIV-positive individuals, some prioritize specific sub-groups). As countries strengthen systems to collect data, there should be regular reporting to PEPFAR Headquarters on changes in eligibility criteria and on systems to track individuals receiving CTX.
Additional Information	• WHO Pre-ART/ART registers http://www.who.int/hiv/pub/imai/imai_registers_preart.pdf • Refer to the PEPFAR Treatment Indicator TWG with further inquiries

Indicator #C2.3.D	3.1.1-73 Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food
Type of Indicator:	Direct
Numerator:	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.
Denominator:	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.
Disaggregation:	By sex, age < 24 months, 24-59 months, 5-14 years, 15+, and pregnancy status/postpartum status
Purpose:	PEPFAR-supported programs provide food support to clinically malnourished clients, including therapeutic food products for severely malnourished clients and supplementary food products for moderately and mildly malnourished clients. This indicator measures the coverage achieved for food support of clinically malnourished clients. It can be used to plan interventions and allocation of resources for food and nutrition as needed, and also to assess the impact of interventions.
Applicability:	All countries with PEPFAR-funded partners providing clinical services or food by prescription to HIV positive individuals. All partners reporting on indicator #C2.2.D.
Data collection frequency:	Data should be collected continuously at the facility or community level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, preferably quarterly for the purposes of program management and review.
Measurement tool:	Program records that document provision of therapeutic and/or supplementary food to clients, and client records that document the nutritional status of clients.
Method of measurement:	The numerator can be generated by counting the number of clinically malnourished clients who received therapeutic and/or supplementary food. Therapeutic foods are defined as foods for the management of severe malnutrition and include products such as ready-to-use therapeutic foods (RUTFs), e.g. <i>PlumpyNut</i>, an energy dense, fortified peanut butter/milk powder-based paste, or other locally produced RUTFs equivalent to F100 therapeutic milk, and therapeutic fortified milks (e.g. F75 and F100),. Supplementary foods for continued treatment of severe malnutrition after an initial stabilization and weight recovery period and for patients who are mild-to-moderately malnourished at entry are primarily fortified, blended flours (e.g. corn-soya blend (CSB)). Food provided for household use or as a safety net does not meet the definition of therapeutic and supplementary food for this indicator (i.e. not based on anthropometric assessment of clinical malnutrition). The denominator can be generated by counting the number of HIV positive clients who were clinically malnourished according to client records at least once in the reporting period. The criterion for malnutrition for this indicator is body mass index (BMI) < 18.5 (wt in kg/ht in m²) for non-pregnant adults and mid-upper arm circumference (MUAC) < 220 mm for pregnant women. Only malnourished pregnant women and children who are HIV positive should be counted in this indicator if they meet the following criteria: for pregnant women - MUAC < 220 mm; for children under age 5 yrs - W/H < -2 Z scores or MUAC <125 mm; for children aged 5-9 yrs W/H < -2 Z scores; and for children aged 10-17 yrs, BMI-for – age < -2 Z scores.
Interpretation:	To address malnutrition and strengthen care and support, a number of PEPFAR countries have introduced therapeutic, supplementary and supplemental food provision in their HIV programs. Results from the indicator provide information about the extent that food support is reaching eligible clients and where gaps may exist. If this indicator is compared across countries, it is important to note that different

	countries and programs may use different types of food products and possibly even different entry and exit criteria for food eligibility. Also, the indicator provides information about coverage, but not about the duration of food support provided to clients, drop-out rates, quality of the foods, or existence of complementary interventions with the food.
Additional Information	PEPFAR Food and Nutrition Technical Guidance and the OVC Programming Guidance on Food and Nutrition. www.pepfar.net under “Guidance” under the “Food and Nutrition” program area as well as the “OVC” program area.

Indicator #C2.4.D	3.1.1-74 Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting
Type of Indicator:	Direct
Numerator:	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting
Denominator:	Denominator is indicator number #C2.1.D (HIV+ Care indicator)
Disaggregation:	
Purpose:	TB disease is the leading cause of mortality among PLWH. Screening for TB among PLWH at initial and subsequent visits is recommended to identify TB suspects and link them to diagnosis and treatment. Currently, available data indicates that despite successes in selected sites, national scale-up of TB screening has been slow in most countries. This indicator will help USG to monitor the proportion of HIV-positive patients who are screened for active TB disease. The data collected from countries using this indicator will allow USG to monitor increases over time. HQ can use this data to identify countries that are making progress and document experiences and lessons learned that may be useful to other countries. HQ can also use this data to identify countries that may require additional programming and technical assistance. Similarly, country teams and partners can use this data to assess scale-up of TB screening among PLWH in specific sites.
Applicability:	All countries with PEPFAR-funded partners providing HIV care or treatment services.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program should modify the revised WHO Pre-ART/ART registers to capture this data in the HIV registers.
Method of measurement:	The numerator can be generated by counting the number of HIV-positive adults and children in HIV care or treatment (pre-ART or ART) who were screened for TB disease during the reporting period, at last visit. Denominator: Indicator #C2.1.D <u>Explanation:</u> <u>Numerator:</u> HIV positive patients should be screened for TB on a regular basis to identify TB suspects and link them to diagnosis and treatment for active TB disease. Currently this information is not fully documented in the revised WHO Pre-ART and ART register. Programs should modify the register as needed to easily capture this information. The TB screening algorithm applied to identify TB suspects who require additional evaluation for TB disease should be consistent with National TB Program recommendations and best practices. This may include a symptom screening questionnaire (i.e. cough, fever, night sweats, recent weight loss, lymphadenopathy) or chest x-ray. Patients who “screen positive” should be referred for further evaluation, diagnosis, and treatment as appropriate. IPT may be considered for eligible patients in whom TB has been excluded if recommended in National Guidelines.

Interpretation:	This indicator is intended to provide information on the proportion of HIV-positive patients in HIV care and treatment who are screened for TB at last visit. We assume that if we check to see if a patient was screened for TB at last visit, this will reflect regular TB screening at each visit. An increase in this indicator suggests that a higher proportion of HIV patients are being screened for TB and increased efforts. For example, developing a standard screening algorithm, training HIV staff, revising cards/registers, etc. A decrease in this indicator suggests that a lower proportion of PLWH are being screened for TB and change in policy or program. For example, a turnover in trained staff, decreased supervision visits, shortage of screening tools, etc.
Additional information:	Partially harmonized with Collaborative activities indicator (TB/HIV-1), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Indicator #C2.5.D	3.1.1-75 Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment
Type of Indicator:	Direct
Numerator:	Number of HIV-positive patients in HIV care who started TB treatment
Denominator:	Program coverage: Indicator number #C2.1.D (HIV+ Clinical care indicator)
Disaggregation:	
Purpose:	All HIV-positive patients should be screened for TB disease. Those patients who “screen positive” are TB suspects and should be linked to additional evaluation, diagnosis, and treatment for TB disease. This indicator will help monitor the proportion of HIV-positive patients who are diagnosed with active TB disease and receive TB treatment. The data collected from countries using this indicator will allow USG to monitor increases over time. HQ can use this data to identify countries that are making progress that might point to best practices and lessons learned that may be useful to other countries. HQ can also use this data to identify countries that may require additional programming and technical assistance. Similarly, country teams and partners can use this data to assess the increase of TB diagnosis and treatment in specific sites.
Applicability:	All countries with PEPFAR-funded partners providing HIV care or treatment services, which include TB screening, diagnosis and treatment.
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, i.e. quarterly, for the purposes of program management and review
Measurement tool:	Revised WHO Pre-ART/ART registers, PEPFAR Facility ART registers/databases, and program monitoring tools.
Method of measurement:	The numerator can be generated by counting the number of HIV-positive adults and children in HIV care or treatment (pre-ART or ART) who were started on TB treatment during the reporting period. Denominator: Indicator #C2.1.D <u>Explanation:</u> <u>Numerator</u> - HIV care and treatment sites should screen HIV patients for TB disease at every visit to identify TB suspects accordingly the national TB screening algorithm for PLWH e.g. symptom screening questionnaire, chest X-ray. In some HIV care and treatment sites, TB diagnosis may be made at the HIV site, but patients may be referred to the TB clinic to start and complete TB treatment. In other HIV care and treatment sites, patients may be screened for TB and then referred to TB clinic for diagnosis and treatment for TB disease as appropriate. Patients identified as TB suspects should be diagnosed for active TB disease based on national diagnostic algorithm in the country. Regardless, linkage between HIV and TB sites is critical to ensure that PLWH who have active TB disease start (and complete) TB treatment accordingly to national TB treatment guidelines in the country. HIV sites should document whether a patient starts TB treatment in the appropriate column on the WHO pre-ART/ART register.
Interpretation:	This indicator is intended to provide information on the proportion of HIV-positive patients in care and treatment that are started on TB treatment. An increase in this indicator over time would suggest improvements in TB screening and access to TB diagnosis and treatment services among HIV patients. This indicator should be interpreted along with the indicator on TB screening. If the results on the TB screening indicator increase, it is expected that the results on this indicator on TB treatment will also increase. Similarly, if the results on the TB

	screening indicator go up, but the results on the TB treatment indicator go down, this may suggest a problem with linking HIV patients to TB diagnosis and treatment services. The indicator would be affected by low uptake of HIV testing, poor access to HIV care services and antiretroviral treatment, and poor access to TB diagnosis and treatment. Separate indicators exist for each of these and should be referred to when interpreting the results of this indicator. This indicator has several limitations that result from the minimal TB data that is collected in HIV sites. The WHO pre-ART/ART register indicates TB treatment start date and stop date but does not indicate whether patients successfully complete TB treatment (i.e. are cured). HIV programs are encouraged to closely monitor TB patients once they start TB treatment and if possible be in contact with TB clinics to ensure that those patients who start TB treatment do complete successfully. Similarly, although it is difficult to obtain data on how many patients were identified as TB suspects and how many patients were actually diagnosed with TB treatment, ideally programs would collect data at each point in the cascade to know what proportion of HIV patients were screened for TB, screened positive (identified as a TB suspect), diagnosed with TB, and treated for TB. However, the data sources and additional time required to report this data may not be realistic for most programs.
Additional Information:	Partially harmonized with indicator #6, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2008 Reporting, United Nations General Assembly Special Session [UNGASS]. April 2007 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf

Indicator #C5.1.D	3.1.1-76 Number of eligible clients who received food and/or other nutrition services		
Type of Indicator:	Direct		
Numerator:	Number of clients who received food and/or nutrition services during the reporting period		
Denominator:	None		
Disaggregation:	Recommended	Males	
	Recommended	Females	
	Essential/reported	<18, 18+ years of age	
	Essential/reported	Pregnant or lactating women	
	Recommended	< 24 months, 24-59 months, 5-17 years	
	Recommended	By service type: Food	
	Recommended	By service type: Nutrition services	
	Recommended	By service type: Food security support (Non-food)	
Purpose:	This indicator measures how many clients receive supplemental food, food security support and/or nutrition services, including therapeutic or supplementary food for OVC whose HIV status is negative or unknown. Results from the indicator provide information about the extent that food support is reaching vulnerable clients and where gaps may exist. It can be used to plan interventions and allocation of resources for food and nutrition. This indicator may also be used for reporting to the U.S. Congress on the number of clients benefiting from PEPFAR-supported food supplementation.		
Applicability:	All countries with PEPFAR-supported partners providing food and nutrition services will report on this indicator.		
Data collection frequency:	Data should be collected continuously at the facility level (or community level). Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation, preferably quarterly for the purposes of program management and review.		
Measurement tool:	Program records that document provision of food support to clients.		
Method of measurement:	The numerator can be generated by counting the total number of clients who received supplemental food (for nutritionally vulnerable clients), therapeutic and supplementary food for OVC whose HIV status is negative or unknown, food security support and/or nutrition services during the reporting period.		
	Clients that receive supplemental food for OVC whose HIV status is negative or unknown, food security support and/or nutrition services more than once during the reporting period should only be counted one time. In order to avoid double counting, countries will need to monitor their activities by partner, programmatic area, and geographic area. The numerator should equal the number of clients who received supplemental, therapeutic, and supplementary food, food security support, and/or nutrition services. It is strongly recommended that these services be provided based a nutrition needs assessment that may include anthropometric assessment, biochemical assessment, clinical assessment of nutritional status, dietary assessment, and food security assessment. For the purposes of reporting on this indicator, individuals receiving at least one of the following food and/or nutrition services should be counted: • Supplemental food support for nutritionally vulnerable children (OVC) • Therapeutic and supplementary food for clinically malnourished orphans and vulnerable children whose HIV status is negative or unknown. (Note: OVC who are HIV positive and receiving therapeutic or supplementary food should be counted in Indicator #C2.3.D). • Supplemental food support for nutritionally vulnerable PMTCT clients • Micronutrient supplements		

	• Nutrition counseling • Promotion of optimal infant and young child feeding • Services to improve food security • School and after-care feeding • Household and community gardens In the absence of unique IDs and electronic monitoring systems it would be challenging to avoid double-counting of clients that receive food supplementation and/or nutrition services more than once during the reporting period. Effort should be made to avoid double-counting at the program level. <u>*Note: Therapeutic and supplementary feeding for severe malnutrition of HIV-positive individuals</u> should be counted under indicator #C2.3.D (See reference sheet for complete definition). If, HIV-positive individuals are receiving additional food services defined by this indicator, they may be counted in this indicator. For example, HIV-positive persons receiving services to improve food security or benefiting from household and community gardens may be counted here. OVCs <u>known</u> HIV positive and receiving therapeutic or supplementary food should be counted in Indicator #C2.3.D.
Interpretation:	It is important to note that the indicator includes a variety of types of food support, including supplemental feeding, addressing food insecurity among PMTCT women and OVC, and other food related services. These are distinct food interventions with distinct objectives, and the total indicator does not provide information about coverage of each individually. If this indicator is compared across countries, it is important to note that different countries and programs may use different types of foods and possibly even different entry and exit criteria for food support. Also, the indicator provides information about the number of clients receiving food and/or nutrition services, but not about the proportion of total clients receiving such food and/or nutrition services, the duration of support provided to clients, drop-out rates, quality of the foods, quality of nutrition services, or existence of complementary interventions with the food; additional alternative types of studies would be need to be conducted to collect the information needed to understand these factors.
Additional information:	PEPFAR Food and Nutrition Technical Guidance and the OVC Programming Guidance on Food and Nutrition. www.pepfar.net under “Guidance” under the “Food and Nutrition” program area as well as the “OVC” program area.

Indicator #T1.3.D	3.1.1-78 Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	
Type of Indicator:	Direct	
Numerator:	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	
Denominator:	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	
Disaggregation:	Essential/reported	<15
	Essential/reported	15+
	<i>Recommended</i>	<15 Males
	<i>Recommended</i>	<15 Females
	<i>Recommended</i>	15+ Males
	<i>Recommended</i>	15+ Females
	Age represents an individual's age at initiation of therapy;	
Purpose:	High retention is one important measure of program success and is a proxy for overall quality of program.	
Applicability:	All countries with PEPFAR-funded partners providing ART services should report on this indicator. This indicator should be reported for PEPFAR Directly supported sites.	
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, data should be aggregated periodically, i.e. quarterly, for the purposes of program management and review.	
Measurement tool:	Program monitoring tools; ART registers/databases and cohort/group analysis forms.	
Method of measurement:	<u>Explanation of Numerator:</u> The numerator requires that adult and child patients must be alive and on ART at 12 months after their initiation of treatment. For a comprehensive understanding of survival, the following data must be collected: • Number of adults and children in the ART start-up groups initiating ART at 12 months prior to the end of the reporting period (denominator) • Number of adults and children still alive and on ART at 12 months after initiating treatment (numerator) The reporting period is defined as a continuous 12-month period that has ended within a pre-defined number of months from the submission of the report. The pre-defined number of months can be determined by PEPFAR or national reporting requirements. If the PEPFAR reporting period is 1 October 2009 to 31 September 2010, countries will calculate this indicator by using all patients who started ART any time during the 12-month period from 1 October 2008 to 31 September 2009. A 12-month outcome is defined as the outcome (i.e. whether the patient is still alive and on ART, dead or lost to follow-up) 12 months after starting. For example, patients who started ART during October 2008 will have reached their 12-month outcomes in October 2009. The numerator does <u>not</u> require patients to have been on ART continuously for the 12-month period. Patients may be included in the numerator (and denominator) if they have missed an appointment or drug pick-up or temporarily stopped treatment during the 12 months since initiating treatment, as long as they are recorded as still being on treatment at month 12. On the contrary, those patients who have died, stopped treatment, or been lost to follow-up as of 12 months since starting treatment are not included in the numerator. For example, for those patients who started ART in October 2008, if at any point during the period October 2008 to October 2009 these patients die, are lost to follow-up (and do not return), or stop treatment (and do not restart), then at month 12 (October 2009), they are not on ART, and not included in the	

	numerator. Conversely, a patient who started ART in October 2008 and who missed an appointment in December 2008, but is recorded as on ART in October 2009 (at month 12) is on ART and will be included in the numerator. The number of adults and children on ART at 12 months includes patients who have transferred in (and their initiation date is known) at any point from initiation of treatment to the end of the 12-month period and excludes patients who have transferred out during this same period to reflect the net current cohort at each facility. What is important is that the patient who has started ART in October 2008 is recorded as being alive and on ART 12 months after initiation, regardless of what happens from October 2008 to October 2009. <u>Explanation of Denominator:</u> The denominator is the total number of adults and children in the (monthly) ART start-up groups who initiated ART at a point 12 months prior to the beginning of the reporting period, regardless of their 12-month outcome. For example, for the reporting period October 1, 2009 to September 30, 2010, this will include all patients who started ART during the 12-month period from October 1, 2008 to September 30, 2009. This includes all patients, both those on ART as well as those who are dead, have stopped treatment or are lost to follow-up at month 12. Again the denominator includes patients that have transferred in (and their initiation date is known) and excludes patients that transferred out during the time period. This indicator should NOT be estimated. This indicator should be calculated directly from information gathered in standard ART registers or tabular analysis from electronic patient level databases. Country teams should ensure that all sites are reporting on the same 12 ART start-up groups. Only sites that have been operational for at least 24 months prior to the end of the reporting period should report, so that all sites report on the same 12 ART start-up groups. Country teams should record how many ART sites are reporting on this indicator and seek to ensure reporting among all eligible ART sites (i.e., operational for 24 months) by the end of FY 2010. Sites are encouraged to disaggregate retention by health status at initiation (e.g. CD4 count or WHO stage), to review the retention of every ART start up group on a continuous basis, to summarize the data at regular intervals (e.g. monthly), and to use this information to improve follow-up and retention of patients.
Interpretation:	At the national level, the number of transferred-in patients should match the number of transferred-out patients. Therefore, the net current cohort (the patients whose outcomes the facility is currently responsible for recording—the number of patients in the start-up group plus any transfers in, minus any transfers out) at 12 months should equal the number in the start-up cohort group 12 months prior. Using this denominator may underestimate true “survival”, since a proportion of those lost to follow-up are alive. The number of people alive and on ART (i.e. retention on ART) in a treatment cohort is captured here. Priority reporting is for aggregate survival reporting. If comprehensive cohort patient registries are available then it is encouraged for countries to track survival at 24, 36, and 48 months. This will enable comparison over time of survival on ART. As it stands, it is possible to identify whether survival at 12 months increases or decreases over time. However, it is not possible to attribute cause to these changes. For example, if survival

	at 12 months increases over time, this may reflect an improvement in care and treatment practices or earlier initiation of ART. Therefore, collection and reporting of survival over longer durations of treatment outcomes may provide a better picture of the long-term success of ART.
Additional Information:	- #24, Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators 2010 Reporting, United Nations General Assembly Special Session [UNGASS]. March 2009 http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf - HIV impact indicator (HIV-I3), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

Indicator #H1.1.D	3.1.1-79 Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
Type of Indicator:	Direct
Numerator:	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
Denominator:	None
Disaggregation:	N/A
Purpose:	An important component for clinical care is laboratory services. In order to support PEPFAR programs, an adequate number of clinical laboratories are needed to perform testing for HIV/AIDS diagnostics, and care and treatment services. Determining the number of laboratories that can perform testing would measure the USG support to build laboratory capacity. This indicator will also serve as a proxy for measuring coverage of HIV/AIDS patient monitoring testing. Countries are encouraged to monitor the numbers of laboratories doing HIV/AIDS related testing and the capacity of these laboratories. This effort seeks to evaluate USG support for laboratory capacity that will provide access to high quality, rapid, affordable diagnostic tests for care, treatment, prevention, and surveillance for HIV/AIDS. Knowing the number of HIV/AIDS clinical laboratories can indicate if testing coverage is adequate or if more capable laboratories are needed.
Applicability:	All countries with USG agencies and/or PEPFAR-funded partners providing HIV/AIDS diagnostics and monitoring test services should report on this indicator.
Data collection frequency:	Data should be aggregated in time for PEPFAR reporting cycles.
Measurement tool:	The number of laboratories is obtained from program records of the PEPFAR-funded partners.
Method of measurement:	A clinical laboratory is counted if the laboratory has the capacity (i.e. infrastructure, dedicated lab personnel, and equipment) to: • Perform testing for the diagnosis of HIV infection with either rapid test, EIA or molecular methods; and, • Perform clinical laboratory tests in any of the following areas: hematology, clinical chemistry, serology, microbiology, HIV/AIDS care and treatment monitoring with CD4 testing or HIV viral loads, TB diagnostic and identification, malaria infection diagnosis, and OI diagnosis. A clinical laboratory can be a physical or mobile structure and must have dedicated laboratory personnel. A facility that does testing for only HIV rapid test diagnosis, such as a VCT or PMTCT site, should not be counted. If a facility is equipped to perform tests, but ran out of reagents or other necessary commodities at the time of reporting, it should still be counted. The laboratory infrastructure will determine a laboratory's capacity to do serology, hematology, microbiology, clinical chemistry, and CD4 testing. A tiered laboratory network is an integrated system of laboratories in alignment with the public health delivery network in a country. In resource-limited settings, there are 3 to 4 levels of laboratories in the national network: 1. Primary health center lab, 2. Secondary district/regional lab, 3. Tertiary regional or provincial lab

	4. National reference lab All laboratories that meet the minimum definition of being capable of or actually performing HIV diagnostic *and* patient monitoring tests should be counted regardless of tiered capacity. Many primary health centers and even some secondary district labs do not have the infrastructure or capacity to provide adequate laboratory testing for HIV/AIDS care and treatment services. In order to provide point-of-care services for HIV/AIDS patients at lower level public health facilities, laboratory infrastructure must be developed and strengthened. Monitoring the number of laboratories capable of providing HIV/AIDS diagnostic and patient monitoring testing seeks to evaluate USG-support to build laboratory capacity. This indicator represents the sum of all PEPFAR-supported laboratories that perform HIV/AIDS related clinical laboratory testing for HIV diagnostics including rapid test, EIA, and molecular methods and have the capacity to perform patient monitoring testing for HIV/AIDS and/or for related infection diagnosis – these tests would include either CD4, hematology, clinical chemistry, HIV viral load, TB diagnostic and identification, malaria diagnosis, STI diagnosis, and OI diagnosis.
Interpretation:	Monitoring the number of laboratories capable of providing testing for PEPFAR programs seeks to evaluate USG-support to build laboratory capacity. This indicator, because of different capacities of laboratories, does not measure adequacy of coverage of laboratory services, but will give indication of trends in delivering laboratory services. It should be noted, laboratories at the higher level will have greater capacity for testing than those at a lower levels. This indicator also does not attempt to measure the quality, cost, and effectiveness of services provided.
Additional Information	- Check List for Annual WHO Accreditation http://wwwn.cdc.gov/dls/ILA/cd/who-afro/LabRpaaccreditationHIV%5B1%5D.doc • Refer to the PEPFAR Treatment/Lab Infrastructure Indicator TWG with further inquiries

Indicator #H1.2.D	3.1.1-80 Percent of testing facilities (laboratories) that are accredited according to national or international standards
Type of Indicator:	Direct
Numerator:	Number of testing facilities (laboratories) that are accredited according to national or international standards
Denominator:	Denominator is lab indicator number H1.1.D Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests
Disaggregation:	
Purpose:	Laboratory services are an essential component in the diagnosis and treatment of persons infected with the human immunodeficiency virus (HIV), and other related diseases of public health significance, including malaria and TB. Presently, the laboratory infrastructure for HIV, malaria, and TB testing and quality assurance remains weak in most PEPFAR-supported countries. There is therefore an urgent need to strengthen the laboratory. The establishment of accreditation systems will help countries to improve and strengthen the capacity of their laboratories. Accreditation provides documentation that the laboratory has the capability and the capacity to detect, identify, and promptly report all diseases of public health significance that may be present in clinical and research specimens. The accreditation process further provides a learning opportunity, a pathway for continuous improvement, a mechanism for identifying resource and training needs, and a measure of progress. This indicator measures the progress and extent to which USG-support has built laboratory capacity, quality, and sustainability by determining the number of accredited clinical laboratories and the laboratories' ability to maintain accreditation over time.
Applicability:	All countries with USG agencies and/or PEPFAR-funded partners providing HIV/AIDS diagnostics and monitoring test services should report on this indicator.
Data collection frequency:	Data should be aggregated in time for PEPFAR reporting cycles.
Measurement tool:	The number of accredited laboratories is obtained from program records of the PEPFAR-funded partners.
Method of measurement:	A PEPFAR-supported clinical laboratory is counted as being accredited if it has received national or international accreditation that meets the World Health Organization (WHO) Accreditation of Public Health Laboratory Networks standard. Full accreditation and levels of accreditation are assessed by a standardized set of criteria defined by WHO Accreditation of National Laboratory Systems or other acceptable international and national standards. Full accreditation is defined by meeting acceptable criteria in order to receive certification by a recognized approved accreditation organization, such as College of America Pathologist (CAP), International Organization for Standardization (ISO), South African National Accreditation System (SANAS), or other WHO approved accreditation organizations. Accreditation certificates are a formal recognition that a laboratory is competent to perform clinical testing. Laboratories may also be assessed using the WHO/AFRO Laboratory Accreditation Checklist. This checklist is specific for the tiered level of the laboratory, either: 1. Primary health center lab, 2. Secondary district/regional lab, 3. Tertiary regional or provincial lab 4. National reference lab. Laboratory will be evaluated in a step-wise process towards full laboratory accreditation using scores on the checklist. Levels of accreditation will be assigned after

	assessment and laboratories that meet a minimal acceptable level will be counted as being accredited. Any fully accredited laboratory that loses accreditation compared to the last reporting year will <u>not</u> be counted. A partially accredited laboratory should be counted. However, if a partially accredited laboratory does not achieve at least one level higher towards full accreditation from that of the previous year, this laboratory should <u>not</u> be counted.
Interpretation:	This indicator monitors the scale up of accreditation practices in testing facilities (laboratories) supported by PEPFAR. This indicator assesses the quality systems of a laboratory and the ability of a laboratory to maintain quality. Determining the number of accredited clinical laboratories, the progress of a laboratory towards accreditation, and the laboratory's ability to maintain accreditation over time provides documentation that the laboratory has the capability and the capacity to perform quality-assured clinical laboratory testing for HIV diagnostic and care and treatment services. Maintaining accreditation is a continuous process and can serve as a measure of sustainability of quality laboratory service. This indicator counts the number of partially accredited laboratories which may not deliver full quality services necessary to support PEPFAR. But it will measure a laboratory's effort to improve on quality as compared to if the laboratory was unmonitored or unaccredited. Accreditation is an assessment of the ability of a laboratory to deliver quality laboratory service. This indicator will not measure the effectiveness of lab accreditation on the delivery of quality services for HIV/AIDS diagnosis, care and treatment. However, the process of assessing labs for accreditation will produce information that can help determine the effectiveness of the laboratory service. These processes include determining testing turn-around times, development of effective workflow, document management, and others. This indicator may undercount the number of accredited facilities as some countries may not at present have the ability to monitor progress toward accreditation or to implement an inspection scheme to accredit a clinical laboratory. Some labs may be capable of receiving an acceptable level of accreditation, but currently the system may lack the means to conduct an accreditation assessment. Development of these monitoring processes and accrediting schemes with the assistance of USG PEPFAR support and implementing partners will help to strengthen in-country laboratory networks and build sustainability.
Additional Information:	- Check List for Annual WHO Accreditation http://wwwn.cdc.gov/dls/ILA/cd/who-afro/LabRpaaccreditationHIV%5B1%5D.doc - Draft WHO Guidelines - Refer to the PEPFAR Treatment/Lab Infrastructure Indicator TWG with further inquiries
Indicator #H2.1.D	3.1.1-82 Number of new health care workers who graduated from a pre-service training institution within the reporting period
Type of Indicator:	Direct
Numerator:	A count of the number of new health care workers who graduated from a pre-service training institution or program
Disaggregation:	By doctors, nurses, midwives (Essential/Reported) By other cadres (Essential/Not Reported). By clinical/non-clinical (Essential/Not Reported)
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to

	scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. PEPFAR has a new legislative goal to produce at least 140,000 new health workers in PEPFAR countries by the end of FY 2013. The intent of this goal is for PEPFAR to support the production of health workers in each country through pre-service training. The data will tell us the number of new health care workers who are available to enter the health work force each year as a result of full or partial PEPFAR support. This indicator is meant to capture the spirit of PEPFAR legislation and will be used in conjunction with other indicators and measures to report to congress on PEPFAR contributions to building the national health workforce.
Applicability:	All USG PEPFAR countries programming in this area will be responsible for reporting on this indicator <u>for Direct and/or National as applicable.</u> This indicator may not be appropriate for tracking a single partner's performance, unless that partner is focused on the mission of increasing the number of health professionals in the workforce. You may need to consider multiple smaller level activities and how they fit together to determine if the support to the graduates of a particular institution is sufficient to count them in your program summary result. <u>Applicability for partner level performance tracking:</u> All partners working in PEPFAR-funded activities with a focus on workforce expansion either through support to pre-service training institutions, tuition support, or education system strengthening and expansion should report on this indicator.
Data collection frequency:	Data should be collected and aggregated in time for PEPFAR reporting cycles.
Measurement tool:	Human Resource Information Systems, pre-service training institutions, professional associations, Ministry of Education or Health Public Service Database HRIS, MOH HRIS, Ministries of Social Welfare HRIS, Councils and other professional associations, Alumni Networks/Graduates Networks, HRH Plans, Implementing partners.
Method of measurement:	The number is the sum of new health care workers from the host country who graduated from a pre-service training institution within the reporting period <u>with full or partial PEPFAR support</u>. Individuals may be in pre-service training over a number of years, but will not count as graduated until they have completed their program. Local pre-service institutions may support other host country nationals under their program but those graduates should not be included in a country's report on this indicator. <u>Explanation:</u> Training under this indicator is defined as "pre-service" training – the training of "new" health care workers (see definition below). All training must occur prior to the individual entering the health workforce in his or her new position. A health care worker who transitions to another position (e.g., nurse completes medical school to become a doctor) shall be counted as a "new" health care worker for the purposes of this indicator. However, the intent of PEPFAR program is to expand the number of workers in the workforce. Pre-service training institutions are university-based or affiliated schools of medicine, nursing, public health, social work, laboratory science, pharmacy, and other health-related fields. Non-professional or paraprofessional training would be any accredited and nationally recognized pre-service program that is a requirement for this cadre's entry into

	the workforce. “In-service” and “continuing education” training should not be included in the count for this indicator, but continue to be encouraged by PEPFAR. These types of training may be captured by other indicators. In order to count the duration of training must meet or exceed a minimum of 6 months. For example, community health care workers who receive a 3-month training course cannot be counted here (use indicator #H2.2.D for pre-service training under 6 months). A pre-service training program must be nationally accredited, or at the minimum meet national and international standards. The program must also have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. Individuals may be in training over many reporting periods; however, only participants who have successfully completed their training should be counted. Successful completion of training may be documented by diploma or certificate. Individuals not meeting these documented requirements should not be counted in this indicator. “Health workers” refers to individuals involved in safeguarding and contributing to the prevention, promotion and protection of the health of the population (both professional and auxiliary-professionals). The categories below describe the different types of health workers to be considered under this indicator. This not an exhaustive list of all health workers and position titles may vary from country to country. For the purposes of this indicator, health workers include the following: 1) Clinical health workers – Clinical health workers play clinical roles in direct service delivery and patient care: a) Clinical professionals, including doctors, nurses, midwives, laboratory scientists, pharmacists, social workers, medical technologists, and psychologists; They usually have a tertiary education and most countries have a formal method of certifying their qualifications. b) Clinical officers, medical and nursing assistants, lab and pharmacy technicians, auxiliary nurses, auxiliary midwives, T&C counselors. They should have completed a diploma or certificate program according to a standardized or accredited curriculum and support or substitute for university-trained professionals. 2) Non-clinical health workers - Non-clinical workers do not play clinical roles in a health care setting but rather include workers in a health ministry, hospital and facility administrators, managers, monitoring and evaluation advisors, epidemiologists and other professional staff critical to health service delivery and program support. Disaggregation of doctors and nurses is Essential/Reported. Countries are asked to also disaggregate by other cadres and clinical/non-clinical (as defined below) but this will not be reported to OGAC (Essential/Not reported). Other disaggregation which is up to the USG team to decide could include- geographical
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	location, training duration, urban/rural, public/private, gender etc. Other disaggregation for this indicator will not be collected at OGAC however, if the data were available by these disaggregations in country and reviewed along with survey or other human resources data, country teams could assess if the numbers and mix of health workers trained adequately match the human resource demands of the health system, according to each country's HRH strategy or plan. Based on this assessment, countries can determine how to prioritize investments in the education, recruitment, deployment and retention and training of health care workers to maximize workforce expansion within the varieties of professionals that are most needed in line with national priorities around HRH. <u>Definition of PEPFAR Direct support</u> Direct PEPFAR support includes funding for full or partial support of student tuition or scholarships. Depending on the country context, direct support can also include investments such as payment of teacher salaries, expansion of pre-service training facilities, and remuneration to recent graduates to 'bridge' the time period between graduation and hiring/deployment. When unclear about the level of PEPFAR support, refer to the principles of the Direct definition contained in this indicator reference guide. In order to be counted, partial support must substantially contribute to pre-service training, meaning that individual or collective PEPFAR contributions must comprise the predominate quantity of support.
Interpretation:	This indicator does not measure the quality of the pre-service training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals from their host country. Pre-service training is an essential component of human resources for health that is planned as part of an overall HRH strategy, which links the production of new health workers with service delivery needs and health systems capacity to recruit and retain newly trained health workers. Data collected by this indicator at the national level can be combined with survey data, workforce vacancy rate data, or other human resources data looking at the number of health workers per 1000 population in order to gain an understanding of the overall impact of pre-service training programs on workforce expansion.
Additional Information:	

Indicator #H2.3.D	3.1.1-84 Number of health care workers who successfully completed an in-service training program within the reporting period
Type of Indicator:	Direct
Numerator:	The number of health care workers who successfully completed an in-service training program
Denominator:	N/A
Disaggregation:	Essential/Reported: Male Circumcision and Pediatrics Essential/Not Reported: All program areas
Purpose:	It is widely acknowledged that the lack of trained health workers is a major barrier to scaling up HIV/AIDS services. The lack of a sufficient workforce in the PEPFAR countries presents a serious challenge not only to HIV/AIDS programs but to every area of health. The data will tell us the number of health care workers who are available to support the mitigation of the HIV/AIDS epidemic each year as a result of full or partial PEPFAR support. This indicator will not be collected at OGAC by cadre of health care worker; however, if the data are available by cadre in country and reviewed along with survey or other human resources data, country teams could gain some understanding about whether the participants completing in-service training programs represent the correct ratio of health care worker cadres and whether the 'mix' of health care workers is the correct 'mix' to meet the human resource demands of the health system, according to each country's epidemiological profile and other factors. Based on this data, countries can determine how to prioritize investments in the education and on-going training of health care workers to maximize workforce expansion and capacity building within the cadres of professionals that are most needed.
Applicability:	All countries with PEPFAR-funded partners with a focus on expanding the quality and capacity of the workforce through the provision of in-service training should report on this indicator.
Data collection frequency:	Data should be collected continuously from training facilities and aggregated in time for PEPFAR reporting cycles. In addition, USG country teams are encouraged to request periodic aggregation from partners, i.e. quarterly, for the purposes of program management and review.
Measurement tool:	Program reports, Human Resource Information Systems, educational institutions, professional associations, Ministry of Education, Labor or Health. Note: these data were collected under PEPFAR I, however, it was done so by program area. Now, it will all be collected under one indicator, but will be disaggregated by program area, so that no new data forms need to be developed.
Method of measurement:	The number is the sum of health care workers who successfully completed an in-service training program within the reporting period with full or partial PEPFAR support. Individuals will not count as having successfully completed their training unless they meet the minimum requirements as defined by international or national standards. In the absence of international or national standards, the minimum requirement will be determined by the PEPFAR country team. Any individual involved in safeguarding and contributing to the prevention, promotion, and protection of the health of the population may be counted in this in-service training indicator. Refer to the pre-service training indicators #H2.1.D and #H2.2.D for illustrative, but not exhaustive, examples of the types of workers one might include. This in-service training indicator includes health workers as illustrated in indicator #H2.1.D and community health and para-social workers as illustrated in #H2.2.D. There are no specific exclusions to this in-service training indicator #H2.3.D.

Explanation:

Training is a learning activity taking place in in-country, a third country, or in the U.S. in a setting predominantly intended for teaching or facilitating the development of certain knowledge, skills or attitudes of the participants with formally designated instructors or lead persons, learning objectives, and outcomes, conducted full-time or intermittently.

Training refers to training or retraining of individuals and must follow a curriculum with stated (documented) objectives and/or expected competencies. Training may include traditional, class-room type approaches to training as well as on the job or “hands-on” training such as clinical mentoring or structured supervision so long as the following three criteria are met:

- 1) Training objectives are clearly defined and documented
- 2) Participation in training is documented (e.g. through sign-in sheets or some other type of auditable training)
- 3) The program clearly defines what it means to complete training (e.g. attend at least four days of a five-day workshop, achieve stated key competencies, score XX% on post-test exam, etc.)

The unit of measure is the number of persons trained or retrained. A person is counted as having been trained if he or she participates in a workshop or course, sponsored with USG support (in whole or in part), with a specific training subject, area, theme or topic. Some examples of training domains are: (1) Delivering home-based care to HIV infected persons; (2) New methods for ensuring financial accountability; (3) Treatment of resistant HIV Infection; (4) Provincial M&E training. If a person attended all four of the above courses, for example, that person should be counted four times. If a person repeats the same training course, he/she should not be counted twice. Please count the staff/volunteers of your organization who were trained, as well as any additional individuals (e.g. from a different organization) that you may have trained in a USG-supported training course that your organization implemented. Only participants who complete the full training course should be counted.

An individual should only be counted once they have completed the training. Individuals that are mid-way through a training course should be counted in the next reporting period. Individuals attending more than one training in a particular program area during a reporting period should only be counted once. Individuals participating in training that covers more than one program area may be counted in each of the respective areas.

If two partners are providing different aspects of training to the same individuals in the same program area (e.g. one partner provides classroom training, another provides clinical mentoring), each partner should report the number of persons uniquely trained by their respective organization, but should note which partner is providing the complementary training role and estimate the number of persons counted by both partners.

In the specific case where USG-supported partners conduct training events that include the staff of sub-grantees, then the prime partner should report all the persons trained, in order to avoid double counting.

In-service training programs are for practicing providers to refresh skills and knowledge or add new material and examples of best practices needed to fulfill their current job responsibilities. In-service training may update existing knowledge and skills, or add new ones. Care should be taken to base trainee selection on content and skill needs. It requires a shorter, more focused period of time than pre-service education, and is often more

	“hands-on.” It can be a workplace activity (led by staff, peers or guest lecturers) or an external event. In-service training can occur through structured learning and follow-up activities, or through less structured means, to solve problems or fill identified performance gaps. In-service training can consist of short non-degree technical courses in academic or in other settings, non-academic seminars, workshops, on-the-job learning experiences, observational study tours, or distance learning exercises or interventions. An in-service training program must meet national or international standards and have specific learning objectives, a course curriculum, expected knowledge, skills, and competencies to be gained by participants, as well as documented minimum requirements for course completion. The duration and intensity of training will vary by cadre; however, all training programs should have at a minimum the criteria listed above. This indicator is distinct and separate from the indicator for pre-service training and education – a health care worker may be counted under both indicators ONLY if that worker has completed pre-service training and education distinct and separate from their in-service training in the same reporting period. Types of In-service Training: 1. Continuing education: Education/training offered to current providers to either update or add new knowledge and skills. While in-service training is often limited to practitioners in the public sector and/or managed by the Ministry of Health (or similar entity), continuing education is often used to describe education/training that is provided by other sources, such as professional associations, that reaches private sector practitioners and which can be linked to re- licensure and/or certification. 2. On-the-job training: Instruction in a specific task or skill is provided via mentoring by a practitioner using explanations, demonstration, practice and feedback. On-the-job training may be combined with academic or technical training to provide a practical experience component. 3. Computer based training: An interactive learning experience in which the computer provides most of the stimuli, the learner responds, and the computer analyzes the responses and provides feedback to the learner. Components most often consist of drill-and practice, tutorial, or simulation activities offered alone or as supplements to traditional instruction. CBT is sometimes also used as a component of a pre-service education course. 4. Distance learning: Distance learning is characterized by a geographic separation of instructor and learner where learners work on their own. It uses a range of mechanisms such as self-guided lesson plans, mailings, radio, and computer based activities. Usually it is tied to an educational facility and uses sequential instructional material that is corrected by the instructor. Regardless of methodologies chosen, it requires motivation on the part of the learner and regular feedback on the part of the learning institution. It can also be used for pre-service education. <u>Explanation of Subsets:</u> MALE CIRCUMCISION TRAINING: Persons who receive in-service training in one or more of the following functions in the delivery of MC for HIV prevention services should be counted in this sub-set: 1) MC provider/surgeon (persons who surgically remove the foreskin, regardless of whether they are a physician, nurse, clinical officer, etc.); 2) surgical assistant;
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	3) counselor (persons who provide education and counseling of clients on MC); and/or 4) ancillary staff (persons who perform sterilization and preparation of surgical instruments/equipment). Training may be for infant or adolescent/adult MC surgical methods. Persons who receive training to perform multiple functions (i.e., as both counselor and surgical assistant), and persons trained in multiple methods (infant and adolescent/adult methods) should only be counted once. Programs should focus on compiling data on male circumcision training from Training Registers maintained by funded programs. MC for HIV prevention services are comprised of a minimum package of components that includes elective surgical male circumcision using local anesthesia provided after education and consent and delivered in the context of comprehensive pre-operative HIV counseling and testing (offer of), pre-operative STI assessment (and treatment when indicated), post-operative HIV risk reduction counseling and abstinence/healing instructions, and provision of condoms. PEDIATRIC TREATMENT TRAINING: Persons who receive in-service training to perform a key function in the pediatric treatment should be counted in this sub-set. Pediatric treatment in-service training will fall into the following categories for this indicator: - Nurse - Counselor - Clinical Officer - Physician - Health Surveillance Advisor (HSA) - Pharmacist In-service training for the purposes of this indicator includes the following modalities in addition to traditional classroom training and workshops: - Issues in pediatric treatment - Dosing for children - Adherence counseling for children - Appropriate clinical monitoring of therapy <u>Definition of PEPFAR support:</u> PEPFAR support includes funding for full or partial support of an in-service training activity, including course development, training materials, trainer salaries, training site rental or renovation, participant per diem and travel costs. When unclear about the level of PEPFAR support, refer to the principles of the Direct definition. You will need to apply these principles to what you are counting.
Interpretation:	This indicator does not measure the quality of the training, nor does it measure the outcomes of the training in terms of the competencies of individuals trained, nor their job performance. This indicator does not measure the placement or retention in the health workforce of trained individuals. Although training is an essential component of human resources for health, programs should plan it in the context of effective human resources management and an overall HRH strategy.
Additional Information:	

Indicator #C4.1.D	3.1.1-85 Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	
Type of Indicator:	Direct	
Numerator:	Number of infants who received an HIV test within 12 months of birth during the reporting period	
Denominator	Number of HIV- positive pregnant women identified in the reporting period (include known HIV- positive at entry)	
Disaggregation:	Essential/reported	Infants who were tested either virologically between 2 and 12 months or serology between 9 and 12 months.
	Essential/reported	Infants who received virological testing in the first 2 months
Purpose:	This indicator measures the extent to which infants born to HIV-positive women are tested to determine their HIV status within the first 12 months of life. Infants infected with HIV during pregnancy, delivery or early postpartum often die before they are recognized as having HIV infection. WHO recommends national programs to establish the capacity to provide early virological testing of infants for HIV at 6 weeks, or as soon as possible thereafter to guide clinical decision-making at the earliest possible stage. Where virological testing is unavailable, initial antibody testing at 9-12 months is recommended. Data from this indicator will be used to: - Determine the rate of scale up and progress with Early Infant Diagnosis with PEPFAR funds; - Help countries to strategize scale-up programs.	
Applicability:	All countries with PEPFAR funded partners supporting HIV testing for infants under the age of 12 months.	
Data collection frequency:	Data should be collected continuously at the facility level. Data should be aggregated in time for PEPFAR reporting cycles. In addition, USG country teams may request periodic aggregation, i.e. quarterly, for the purposes of program management and review.	
Measurement tool:	Patient records, service outlet log books, HIV-exposed infant registers or other auditable source documentation at PEPFAR supported facilities	
Method of measurement:	Numerator: The numerator is calculated from PEPFAR supported program records compiled from data collected in registers at facilities. <u>Explanation of Numerator:</u> The numerator, Number of infants who received an HIV test within 12 months in the reporting period, should be disaggregated as follows: 1) infants who received virological testing in the first 2 months 2) Infants that were tested either virologically between 2 and 12 months, or by serology between 9 and 12 months. Infants tested should only be counted once. The numerator should only include the initial test and not any subsequent tests Data should be aggregated from the appropriate facility registers, which could include integrated MCH registers, HIV-exposed infant follow-up registers, lab records, or pre-ART registers. The register used may vary depending on the country context. For example, where HIV-exposed infant follow-up takes place in the care and treatment setting, countries may aggregate information either from a pre-ART register adapted for HIV-exposed infant follow-up or in a separate HIV-exposed infant register.	
Interpretation:	This indicator allows countries to monitor progress in reaching HIV-exposed infants with early infant testing as a critical tool for providing appropriate follow-up care and treatment. Countries may have difficulty distinguishing between initial and subsequent tests, which need to be done to avoid double-counting. While ideally the indicator captures infants born to known HIV-positive women, it may not	

	be feasible in some settings to exclude infants who were tested for HIV using virological testing or antibody testing through provider initiated testing, such as in pediatric wards, malnutrition centers, and other settings where infants may be identified as exposed or infected. Double counting may also skew the number of reported tests. Because most countries do not have a unique identifier system set up for testing infants, and many infants are tested more than once, it is likely that the numerator may indicate a higher number of infants receiving a test than what is happening in reality. It does not capture the number of children with a definitive diagnosis (i.e. either confirmed or excluded of HIV infection), or measure whether appropriate follow-up services were provided to the child based on interpretation of test results. The indicator does not measure the quality of testing or the system in place for testing. A low value of the indicator could, however, signal potential bottlenecks in the system, including poor management of HIV testing supply in country, poor data collection, and mismanagement of testing samples.
Additional Information:	- #8, Guidance and Specifications for Additional Recommended Indicators, Addendum to: UNGASS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on Construction of Core Indicators. 2008 Reporting. April 2008. http://data.unaids.org/pub/BaseDocument/2009/20090305_additionalrecommendedindicators_finalprintversio_en.pdf - Prevention indicator (HIV-P13), The Global Fund to Fight AIDS, Tuberculosis and Malaria Monitoring and Evaluation Toolkit: HIV, Tuberculosis and Malaria and Health Systems Strengthening, Part 2: Tools for monitoring programs for HIV, tuberculosis, malaria and health systems strengthening, Third Edition, February 2009 http://www.theglobalfund.org/documents/me/M_E_Toolkit_P2-HIV_en.pdf

3.1.1—Tuberculosis

Indicator	3.1.2-30 Percent of registered new smear positive pulmonary TB cases that were cured and completed treatment under DOTS nationally (Treatment Success Rate)
Definition	Numerator: Number of new sputum smear positive pulmonary TB cases registered in a specified time period that were cured plus the number that completed treatment in the same specified time period Denominator: Total number of new smear positive TB cases registered in the same specified time period (x 100) The indicator measures a program's capacity to retain patients through a complete course of chemotherapy with a favorable clinical result. "Cured" are the cases bacteriologically confirmed treated and "completed" are the cases that complete treatment with clinical improvements but without bacteriological confirmation of cure. This indicator reflects only new cases for the reporting year and does not represent a running total beyond that year.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	For most countries, the facilities send their treatment registries to the district level. The district level develops a quarterly report on treatment outcomes. The NTP combines them for all the districts and creates a national report for the year. These reports are provided to WHO and they produce an annual report for all the reporting countries. The annual report can be found at the following website: http://www.who.int/tb/country/en/index.html
Known Data Limitations	The completeness of the report at the facility level is a limitation of the data. It could result in unaccounted and/or incorrect outcomes of some cases.
Baseline Timeframe	Collected since 1998 in the WHO annual report (link above)
Disaggregate(s)	By sex; Numerator, Denominator

Indicator	3.1.2.1-2 Case notification rate in new sputum smear positive pulmonary TB cases per 100,000 population nationally
Definition	Case Notification Rate (CNR) is the number of TB cases reported to the NTP per year per 100,000 population. Numerator: Number of new sputum smear positive pulmonary TB cases reported in the past year Denominator: Total population in the specified geographic area (x 100,000) This indicator reflects only new cases for the reporting year and does not represent a running total beyond that year.
Linkage to Long-Term Outcome or Impact	Internationally recognized indicator that measures changes in the TB program's capacity to find TB cases. An upward trend in case notification can reflect improvement in program performance to find cases. In some cases, it can reflect the impact of HIV/AIDS since TB is the leading infectious cause of death among people with HIV.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	For most countries, the facilities send their treatment registries to the district level. The district level develops a quarterly report with the number of cases notified. The NTP combines them for all the districts and creates a national report for the year. These reports are provided to WHO and they produce an annual report for all the reporting countries. The annual report can be found at the following website: http://www.who.int/tb/country/en/index.html
Known Data Limitations	Case notification represents only a subset of the true number of cases arising in the country because of the incomplete coverage by health services, inaccurate diagnosis, or deficient recording and reporting. Notifications reported by MOH often do not include cases managed by the private sector (Note: This is the reason for indicator 5). Although in most countries case notifications underrepresent the burden of disease, they often represent the most useful data for estimating incidence.
Baseline Timeframe	Collected since 1998 in the WHO annual report (link above)

Indicator	3.1.2.1-3 Number of new TB cases reported to National Tuberculosis Programs (NTP) by non-MOH organizations
Definition	Number of TB cases reported to NTP by non-MOH organizations. Non-MOH organizations could be prisons, social security facilities, not-for-profit or for-profit private facilities, clinics and hospitals for military and police, or faith-based facilities. This indicator reflects only new cases for the reporting year and does not represent a running total beyond that year.
Linkage to Long-Term Outcome or Impact	The GHI seeks to increase the TB case detection. The non-MOH organizations can play an important role in diagnosing and treating TB cases. The implementation of quality TB interventions by such organizations is important in achieving this objective.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	Most countries require TB case to be notified to the government. In many countries, the non-MOH organizations have an agreement with the NTP to report to them on a quarterly basis on the number of people registered with TB. The NTP sometimes gives the private sector free drugs to promote the relationship and ensure reporting. USAID Project Reports/WHO Annual Report The annual report can be found at the following website: http://www.who.int/tb/country/en/index.html
Known Data Limitations	The completeness of the information at the facility level is a limitation of the data. It could result in unaccounted and/or incorrect data.
Baseline Timeframe	Collection initiation time is country specific and only among the private sector facilities involved in the collaboration. It depends when they started their first PPM activities
Disaggregate(s)	N/A

Indicator	3.1.2.1-4 Percent of USG-supported laboratories performing TB microscopy with 95 percent or higher rate of correct results
Definition	Numerator: Number of laboratories with 95% or higher rate of correct microscopy results Denominator: Total number of laboratories performing TB microscopy Percent of correct results is verified via an external quality assurance check by a reference lab.
Linkage to Long-Term Outcome or Impact	One GHI target is to increase detection of cases. This indicator measures the quality of smear microscopy at the facility level. NTPs should have a smear microscopy QA system that is monitored by the national or regional reference lab. The early and correct detection of TB cases is important to starting people on treatment sooner, resulting in an overall decrease in infections and mortality.
Indicator Type	Output
Unit of Measure	Percent
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	The regional and national reference labs collect this data and report it to the NTP. It is also usually confirmed by the USAID projects. USAID Project Reports/Annual
Known Data Limitations	The completeness of the information at the lab conducting the quality assurance is a limitation of the data. It could result in unaccounted and/or incorrect data. If it is a small number of labs in a small country, it could significantly change the percent. If the lab conducting the QA is poor quality, the results will be inaccurate.
Baseline Timeframe	Collected since 2005 in select countries and under select projects.
Disaggregate(s)	Numerator, Denominator

Indicator	3.12.1-5 National TB smear microscopy laboratory coverage
Definition	This indicator represents the average population served per TB microscopy unit Numerator: Total population of the country Denominator: Number of TB smear microscopy laboratories the country
Linkage to Long-Term Outcome or Impact	One GHI target is to increase detection of cases. This indicator measures the national coverage of diagnostic services to achieve this objective. The early and correct detection of TB cases is important to starting people on treatment sooner, resulting in an overall decrease in infections and mortality.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting, etc
Data Source and Reporting Frequency	The NTP has the information on the number of labs and the census data is used for the total populations. It is also sometimes confirmed by the USAID projects. USAID Project Reports/Annual
Known Data Limitations	The number of labs may change over time and there may be a lag in when the information gets reported to the NTP. There may also be unofficial movements in populations that affect the denominator. However, the trends over time would like make up for any of these discrepancies.
Baseline Timeframe	Collected since 2005 in select countries and under select projects.
Disaggregate(s)	N/A

Indicator	3.1.2.2-1 Percent of TB patients tested for HIV
Definition	Numerator: Number of registered TB patients who are tested for HIV Denominator: Total number of registered TB patients This indicator reflects only those TB patients who were tested for HIV in the reporting year and does not represent a running total over time.
Linkage to Long-Term Outcome or Impact	This indicator will be used to increase case detection, quality of treatment and care of individuals to address the dual infections. Testing TB patients for HIV is in direct support of overall GHI TB objectives.
Indicator Type	Output
Unit of Measure	Percent
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	WHO Annual Report/Annual
Known Data Limitations	
Baseline Timeframe	
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.2.3-1 Number of new multi-drug resistant TB (MDR TB) diagnosed patients initiated on treatment
Definition	This indicator represents the total number of all diagnosed MDR TB patients who also started treatment. MDR TB is TB that is resistant to at least the two most powerful anti-TB drugs (isoniazid and rifampicin). Since a small number of the estimated number of MDR TB patients in developing countries have been diagnosed and initiated on treatment, this is an important indicator to monitor over the next five years. This indicator reflects only new cases for the reporting year and does not represent a running total beyond that year.
Linkage to Long-Term Outcome or Impact	The presence of MDR TB is an indication of a poor performing TB program. Since a small number of the estimated number of MDR TB patients in developing countries have been diagnosed and initiated on treatment, this is an important indicator to monitor over the next five years. One of the two TB targets for GHI is to diagnose and initiate on treatment 57,200 MDR TB cases among the USG TB countries.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	For most countries, there are only a few facilities that can treat for MDR TB. These facilities send the NTP the number of people initiated treatment to the NTP. The USAID Missions collect this information.
Known Data Limitations	The completeness of the report at the facility level is a limitation of the data. It could result in unaccounted and/or incorrect number of some cases.
Baseline Timeframe	Collected since 2009 in the WHO annual report (link above)
Disaggregate(s)	By sex

Indicator	3.1.2.3-2 Percent of successfully treated MDR TB (category IV TB) cases
Definition	This indicator represents the treatment success rate among registered category IV TB patients who had received second line anti-TB drug regimen. A treatment is considered successful if it results in the patient being that were cured and completed treatment with second line anti-TB drugs. A second line anti-TB drug regimen does not include the use of the two most powerful anti-TB drugs due to resistance. There are six classes of second line anti-TB drugs used to treat MDR TB. Numerator: Total number of category IV TB patients receiving second line anti-TB drugs registered in a specified time period that were cured plus the number that completed treatment in the same specified time period. Denominator: Total number of category IV TB cases receiving second line anti-TB drugs. This indicator reflects only new cases for the reporting year and does not represent a running total beyond that year.
Linkage to Long-Term Outcome or Impact	The presence of MDR TB is an indication of a poor performing TB program. This indicator measures a program's capacity to retain MDR TB patients through a complete 2 year course of TB treatment with favorable clinical results. There is a direct link between the treatment success rate and the impact of reduced TB mortality.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting, etc
Data Source and Reporting Frequency	For most countries, there are only a few facilities that can treat for MDR TB. These facilities send the NTP the number of people successfully treated for MDR TB to the NTP. The USAID Missions collect this information.
Known Data Limitations	The completeness of the report at the facility level is a limitation of the data. It could result in unaccounted and/or incorrect outcomes of some cases.
Baseline Timeframe	Collection initiation time is country specific. It depends when they started their first MDR TB program.
Disaggregate(s)	By sex; Numerator, Denominator

Indicator	3.1.2.9-1 Number of participants in a country trained in the components of the WHO Stop TB Strategy with USG funding
Definition	This indicator counts the number of participants in a country, such as medical personnel, laboratory technicians, health workers, community workers, or others who complete TB related training lasting one day or more) that was funded by the USG. A person is counted each time s/he completes the type of training specified above, such that one person can be counted multiple times.
Linkage to Long-Term Outcome or Impact	This is one indicator of USG support for building local capacity to deliver the various components of the TB program supported by the USG.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Program Performance, Trends of Country Progress, Congressional Reporting
Data Source and Reporting Frequency	USAID Project Reports/Annual
Known Data Limitations	People can be double counted because it is the number of participants trained. One person can be a participant in more than 1 training per year. Also, it does not measure the quality of the training or the knowledge gained from the training. Lastly, the completeness of the information submitted could be a limitation of the data. It could result in unaccounted and/or incorrect data.
Baseline Timeframe	Collected since the beginning of USAID TB program in 2000
Disaggregate(s)	By sex;

3.1.3 – Malaria

Indicator	3.1.3-44 Under-Five Mortality Rate
Definition	<u>Numerator:</u> Number of all-cause deaths among children under age 5 in a given year <u>Denominator:</u> Number of live births in the same year/1000
Linkage to Long-Term Outcome or Impact	The overall goal for this program is for this number to go down, indicating a decreased number of deaths in children under the age of 5.
Indicator Type	Impact
Unit of Measure	Number of deaths per 1000 live births in the same period
Use of Indicator	To evaluate the impact of interventions. This information would be used by Bureau-level planners, Congress, partner governments, and other stakeholders. Under-5 mortality rate is a leading indicator of the level of child health/survival and overall development in countries. It is a key indicator for GHI as well as being the indicator to measure MDG 4: reduction of child mortality.
Data Source and Reporting Frequency	<u>Data Sources:</u> Household surveys (DHS, MICS, MIS) www.measuredhs.com www.childinfo.org www.malariasurveys.org <u>Reporting Frequency:</u> When surveys are available. The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years, the MICS every 3 years, and the MIS does not always include mortality data. These surveys are not conducted on an annual basis in any given country so reporting on this indicator for a specific country can only be done when the above surveys are scheduled, which could be every 3-5 years.
Known Data Limitations	These surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation. For further limitations on this indicator and the methods used to collect this information, refer to the 3 survey websites listed above.
Baseline Timeframe	Varies by country.
Disaggregate(s)	Sex, Urban/Rural, Wealth quintiles

Indicator	3.1.3.1-1 Number of health workers trained in case management with artemisinin-based combination therapy (ACTs) with USG funds
Definition	Number of health workers (doctor, nurse, nurse's assistant, clinical officer or community/village health worker) trained in case management with artemisinin-based combination therapy (ACTs) with USG funds.
Linkage to Long-Term Outcome or Impact	Training health workers in case management of ACTs will help ensure that patients with malaria are treated. In severe malaria cases, treating with ACTs can prevent death. (linkage to U5MR impact indicator)
Indicator Type	Output
Unit of Measure	Number of people, Specific to the year
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a training roster. <u>Reporting Frequency:</u> Annual
Known Data Limitations	Any training indicator has the fundamental problem of only capturing the training provided. The quality of the training nor the outcome of the training (whether the trainees learned any skills or whether they will use the taught skills) are measured with these indicators.
Baseline Timeframe	Varies by country.
Disaggregate(s)	Sex

Indicator	3.1.3.1-2 Number of artemisinin-based combination therapy (ACT) treatments purchased by other partners that were distributed with USG funds
Definition	Number of ACT treatments purchased by other partners (not USG) but were distributed (to central, regional, or district health facility) with USG funds
Linkage to Long-Term Outcome or Impact	Linkage to impact – ensuring that life-saving drugs are being delivered.
Indicator Type	Output
Unit of Measure	Number of treatments
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs) or signed delivery note. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of ACTS purchased and planned for distribution that have not actually been distributed yet to health facilities
Baseline Timeframe	Varies by country.
Disaggregate(s)	

Indicator	3.1.3.1-3 Number of artemisinin-based combination therapy (ACT) treatments purchased with USG funds
Definition	Number of ACT treatments purchased with USG funds
Linkage to Long-Term Outcome or Impact	Linkage to impact – ensuring that life-saving drugs are available.
Indicator Type	Output
Unit of Measure	Number of treatments
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a purchase order/invoice. <u>Reporting Frequency:</u> Annually
Known Data Limitations	No known data limitations since these are directly from purchase orders and invoices of ACTs already procured.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.1-4 Number of artemisinin-based combination therapy (ACT) treatments purchased with USG funds that were distributed
Definition	Number of ACT treatments purchased with USG funds that were distributed to health facilities, to community health workers (HBMF, CCM), to the private/commercial sector
Linkage to Long-Term Outcome or Impact	Linkage to impact – ensuring that life-saving drugs are available.
Indicator Type	Output
Unit of Measure	Number of treatments
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs) or signed delivery note. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of ACTS purchased and planned for distribution that have not actually been distributed yet to health facilities or health workers
Baseline Timeframe	Varies by country
Disaggregate(s)	Show distribution breakdown by health facilities, community health workers (HBMF CCM), and private/commercial sector

Indicator	3.1.3.1-5 Number of health workers trained in malaria laboratory diagnostics (rapid diagnostic tests (RDTs) or microscopy) with USG funds
Definition	Number of health workers (doctor, nurse, nurse's assistant, clinical officer, community/village health worker, laboratorian), trained in malaria laboratory diagnostics (RDTs or microscopy) with USG funds
Linkage to Long-Term Outcome or Impact	Training health workers in malaria diagnosis improves recognition of malaria cases and appropriate treatment in those with malaria, and reduces over treatment or mistreatment of those without malaria
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. The primary data source is a training roster. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Any training indicator has the fundamental problem of only capturing the training provided. The quality of the training nor the outcome of the training (whether the trainees learned any skills or whether they will use the taught skills) are measured with these indicators.
Baseline Timeframe	Varies by country
Disaggregate(s)	Sex, Urban/Rural, Wealth quintiles

Indicator	3.1.3.1-6 Number of malaria rapid diagnostic tests (RDTs) purchased with USG funds
Definition	Number of RDTs purchased with USG funds.
Linkage to Long-Term Outcome or Impact	RDT purchase leads to an increase in the number of correct diagnostic and treatment episodes for malaria and improves case management for malaria
Indicator Type	Output
Unit of Measure	Number of RDTs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. The primary data source is a purchase order/invoice. <u>Reporting Frequency:</u> Annually
Known Data Limitations	No known data limitations since these are directly from purchase orders and invoices of RDTs already procured.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.1-7 Number of rapid diagnostic tests (RDTs) purchased with USG funds that were distributed to health facilities
Definition	Number of RDTs purchased with USG funds that were distributed to health facilities (hospital, health center, health post/station, or clinic).
Linkage to Long-Term Outcome or Impact	RDT distribution leads to an increase in the number of correct diagnostic and treatment episodes for malaria and improves case management for malaria.
Indicator Type	Output
Unit of Measure	Number of RDTs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs) or signed delivery note. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of RDTs purchased but not yet distributed.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.2-1 Number of insecticide treated nets (ITNs) purchased by other partners that were distributed with USG funds
Definition	Number of ITNs purchased by other partners that were distributed with USG funds.
Linkage to Long-Term Outcome or Impact	Linkage to the outcome indicator on household ownership of ITNs as well as the use of ITNs.
Indicator Type	Output
Unit of Measure	Number of ITNs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs) or signed delivery note. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of ITNs that have not yet been distributed.
Baseline Timeframe	Varies by country
Disaggregate(s)	None

Indicator	3.1.3.2-2 Number of insecticide treated nets (ITNs) purchased with USG funds
Definition	Number of ITNs purchased with USG funds
Linkage to Long-Term Outcome or Impact	ITNs purchase and distribution leads to increased population coverage with ITNs which reduces the number of malaria infections, illnesses, and deaths.
Indicator Type	Output
Unit of Measure	Number of ITNs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a purchase order/invoice. <u>Reporting Frequency:</u> Annually
Known Data Limitations	No known data limitations since these are directly from purchase orders and invoices of ITNs already procured.
Baseline Timeframe	Varies by country.
Disaggregate(s)	

Indicator	3.1.3.2-3 Number of insecticide treated nets (ITNs) purchased with USG funds that were distributed
Definition	Number of ITNs purchased with USG funds that were distributed • Through campaigns, • Through health facilities (ANC or child health clinics), • Through the private/commercial sector, • Through other distribution channels
Linkage to Long-Term Outcome or Impact	Linkage to the outcome indicator on household ownership of ITNs as well as the use of ITNs
Indicator Type	Output
Unit of Measure	Number of ITNs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs), signed delivery note, or campaign records. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of ITNs that have been purchased but not yet distributed.
Baseline Timeframe	Varies by country.
Disaggregate(s)	• through campaigns, • through health facilities • through the private/commercial sector, • through other distribution channels

Indicator	3.1.3.2-4 Number of insecticide treated nets (ITNs) re-treated with insecticides with USG funds
Definition	Number of ITNs re-treated with insecticides with USG funds
Linkage to Long-Term Outcome or Impact	ITN retreatment improves their ability to prevent malaria infection which reduces the number of malaria infections, illnesses, and deaths.
Indicator Type	Output
Unit of Measure	Number of ITNs
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source are records from retreatment campaigns. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include the potential reporting of ITNs that are planned for re-treatment but have not yet been re-treated.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.2-5 Proportion of households with at least one insecticide-treated net (ITN)
Definition	<u>Numerator:</u> Number of households surveyed with at least one ITN <u>Denominator:</u> Total number of households surveyed
Linkage to Long-Term Outcome or Impact	With more households owning nets, there will be more use of nets, which then will prevent malaria.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners. This indicator helps track progress towards program targets and goals.
Data Source and Reporting Frequency	<u>Data Sources:</u> Household surveys (DHS, MICS, MIS) is there a url? www.measuredhs.com www.childinfo.org www.malariasurveys.org <u>Reporting Frequency:</u> When surveys are available. The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years, the MICS every 3 years, and the MIS does not always include mortality data. These surveys are not conducted on an annual basis in any given country so reporting on this indicator for a specific country can only be done with the above surveys are scheduled which could be every 3-5 years.
Known Data Limitations	These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. For further limitations on this indicator and the methods used to collect this information, refer to the 3 survey websites listed above.
Baseline Timeframe	Varies by country.
Disaggregate(s)	Urban/Rural, Wealth quintiles (lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm); Numerator, Denominator

Indicator	3.1.3.2-6 Proportion of children under 5 years old who slept under an insecticide-treated net (ITN) the previous night
Definition	<u>Numerator:</u> Number of children under 5 years old who slept under an ITN the previous night <u>Denominator:</u> Total number of children under 5 years old who spent the previous night in surveyed households.
Linkage to Long-Term Outcome or Impact	This is an outcome indicator. With increased use of nets there will be declining prevalence in malaria.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners. This indicator helps track progress towards program targets and goals.
Data Source and Reporting Frequency	<u>Data Sources:</u> Household surveys (DHS, MICS, MIS) url? www.measuredhs.com www.childinfo.org www.malariasurveys.org <u>Reporting Frequency:</u> When surveys are available. The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years, the MICS every 3 years, and the MIS does not always include mortality data. These surveys are not conducted on an annual basis in any given country so reporting on this indicator for a specific country can only be done when the above surveys are scheduled which could be every 3-5 years.
Known Data Limitations	These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. For further limitations on this indicator and the methods used to collect this information, refer to the 3 survey websites listed above.
Baseline Timeframe	Varies by country.
Disaggregate(s)	Sex, Urban/Rural, Wealth quintiles; Numerator, Denominator

Indicator	3.1.3.2-7 Proportion of pregnant women who slept under an insecticide-treated net (ITN) the previous night
Definition	Numerator: Number of pregnant women who slept under an ITN the previous night. Denominator: Total number of pregnant women within surveyed households
Linkage to Long-Term Outcome or Impact	With increased use of nets there will be declining prevalence in malaria.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners. This indicator helps track progress towards program targets and goals.
Data Source and Reporting Frequency	<u>Data Sources:</u> Household surveys (DHS, MICS, MIS) www.measuredhs.com www.childinfo.org www.malariasurveys.org <u>Reporting Frequency:</u> When surveys are available. The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years, the MICS every 3 years, and the MIS does not always include mortality data. These surveys are not conducted on an annual basis in any given country so reporting on this indicator for a specific country can only be done when the above surveys are scheduled which could be every 3-5 years.
Known Data Limitations	These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. Limitations include that the data are based on report of behavior rather than observation of behavior For further limitations on this indicator and the methods used to collect this information, refer to the 3 survey websites listed above.
Baseline Timeframe	Baselines for the outcome and impact indicators differ by country. The baselines are dependent on the timing of national surveys.
Disaggregate(s)	Urban/Rural, Wealth quintiles; Numerator, Denominator

Indicator	3.1.3.3-1 Number of people trained with USG funds to deliver indoor residual spraying (IRS)
Definition	Number of people trained with USG funds to deliver IRS – only include spray personnel such as spray operators, team leaders, supervisors, and clinicians. Exclude data clerks, IEC mobilizers, drivers, washers, porters, pump technicians and security guards from this number
Linkage to Long-Term Outcome or Impact	Training people in IRS delivery leads to increased coverage with IRS which leads to decreased exposure to mosquito vectors and decreased infections, illness and deaths due to malaria
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a training roster. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include reporting individuals who are planned to be trained as having already received training. Any training indicator has the fundamental problem of only capturing the training provided. The quality of the training nor the outcome of the training (whether the trainees learned any skills or whether they will use the taught skills) are measured with these indicators.
Baseline Timeframe	Varies by country
Disaggregate(s)	Sex

Indicator	3.1.3.3-2 Number of houses targeted for spraying with USG funds
Definition	Number of houses targeted for spraying with USG funds - report the number of houses that were located in the geographic area that was to be sprayed. This should NOT be an estimate (i.e. not a planning figure or MOP figure). It should be the actual count of eligible structures found and knocked on by spray operators in the geographic area that was targeted for spraying.
Linkage to Long-Term Outcome or Impact	Targeting houses for spraying leads to increased coverage with IRS which leads to decreased exposure to mosquito vectors and decreased infections, illness and deaths due to malaria.
Indicator Type	Output
Unit of Measure	Number of houses
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is spray campaign records. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include potential undercount of structures needing spraying.
Baseline Timeframe	Varies by country
Disaggregate(s)	Cannot be disaggregated

Indicator	3.1.3.3-3 Number of houses sprayed with IRS with USG funds
Definition	Number of houses sprayed with IRS with USG funds – report the actual number of houses that were sprayed. This should NOT be an estimate. This should be a subset of all structures found that were eligible for spraying.
Linkage to Long-Term Outcome or Impact	Spraying leads to decreased exposure to mosquito vectors and decreased infections, illness and deaths due to malaria.
Indicator Type	Output
Unit of Measure	Number of houses
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is spray campaign records. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include potential reporting of structures as having been sprayed that have not actually been sprayed.
Baseline Timeframe	Varies by country
Disaggregate(s)	Cannot be disaggregated

Indicator	3.1.3.3-4 Total number of residents of sprayed houses
Definition	Total number of residents of sprayed houses – report the number of residents living in the houses that were sprayed. This should NOT be an estimate. It should be an actual count of the persons residing in the sprayed houses.
Linkage to Long-Term Outcome or Impact	Increasing the number of people protected by IRS leads to decreased exposure to mosquito vectors and decreased infections, illness and deaths due to malaria
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is spray campaign records. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include potential over reporting of the number of people living in structures that have been sprayed.
Baseline Timeframe	Varies by country
Disaggregate(s)	Disaggregate by sex, if possible

Indicator	3.1.3.4-1 Number of health workers trained in intermittent preventive treatment in pregnancy(IPTp) with USG funds
Definition	Number of health workers (doctor, nurse, nurse's assistant, clinical officer) trained in IPTp with USG funds.
Linkage to Long-Term Outcome or Impact	Training health workers in IPTp leads to increased provision of appropriate IPTp to pregnant women which decreases malaria infections in women. This leads to decreased number of women with anemia and placental malaria, decreased prevalence of low birth weight, and decreased infant deaths associated with low birth weight.
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a training roster. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include potential reporting health workers as having been trained when training has not yet been actually delivered. Any training indicator has the fundamental problem of only capturing the training provided. The quality of the training nor the outcome of the training (whether the trainees learned any skills or whether they will use the taught skills) are measured with these indicators.
Baseline Timeframe	Varies by country
Disaggregate(s)	Sex, Urban/Rural

Indicator	3.1.3.4-2 Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds
Definition	Number of SP tablets purchased with USG funds
Linkage to Long-Term Outcome or Impact	SP tablets are needed to give to women for IPTp. IPTp decreases malaria infections in women. This leads to decreased number of women with anemia and placental malaria, decreased prevalence of low birth weight, and decreased infant deaths associated with low birth weights.
Indicator Type	Output
Unit of Measure	Number of SP tablets
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a purchase order/invoice. <u>Reporting Frequency:</u> Annually
Known Data Limitations	No known data limitations since these are directly from purchase orders and invoices of SP already procured.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.4-3 Number of sulfadoxine-pyrimethamine (SP) tablets purchased with USG funds that were distributed to health facilities
Definition	Number of SP tablets purchased with USG funds that were distributed to health facilities (hospitals, health centers, health posts/stations, clinics).
Linkage to Long-Term Outcome or Impact	Distribution of SP tablets improves coverage with IPTp. IPTp decreases malaria infections in women. This leads to decreased number of women with anemia and placental malaria, decreased prevalence of low birth weight, and decreased infant deaths associated with low birth weight.
Indicator Type	Output
Unit of Measure	Number of SP tablets
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners.
Data Source and Reporting Frequency	<u>Data Sources:</u> Implementing partner reports. Primary data source is a proof of delivery (PODs) or signed delivery note. <u>Reporting Frequency:</u> Annually
Known Data Limitations	Limitations include reporting as distributed SP tablets that have not yet been distributed.
Baseline Timeframe	Varies by country
Disaggregate(s)	

Indicator	3.1.3.4-4 Proportion of Women who Received Intermittent Preventive Treatment (IPT) during Antenatal Care (ANC) visits during their last pregnancy
Definition	<u>Numerator:</u> Number of women who received two or more doses of a recommended anti-malarial drug treatment during ANC visits to prevent malaria during their last pregnancy that led to a live birth within the last 2 years. <u>Denominator:</u> Total number of women surveyed who delivered a live baby within the last 2 years.
Linkage to Long-Term Outcome or Impact	Linkage to overall impact of the program since the use of IPT prevents malaria during pregnancy among women.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	The indicator is used for program planning, budgeting and reporting. The indicator is used by country managers and partners. This indicator helps track progress towards program targets and goals.
Data Source and Reporting Frequency	<u>Data Sources:</u> Household surveys (DHS, MICS, MIS) www.measuredhs.com www.childinfo.org www.malariasurveys.org <u>Reporting Frequency:</u> When surveys are available. The timeframe for these surveys in any given country will be different. The DHS is implemented every 5 years, the MICS every 3 years, and the MIS does not always include mortality data. These surveys are not conducted on an annual basis in any given country so reporting on this indicator for a specific country can only be done when the above surveys are scheduled which could be every 3-5 years.
Known Data Limitations	These surveys are not conducted annually, so data may not be available at the optimal intervals for evaluation. For further limitations on this indicator and the methods used to collect this information, refer to the 3 survey websites listed above.
Baseline Timeframe	Varies by country.
Disaggregate(s)	Urban/Rural, Wealth quintiles; Numerator, Denominator

3.1.5 – Other Public Threats

Indicator	3.1.5-32 Number of Neglected Tropical Disease (NTD) Treatments delivered through USG-funded programs.
Definition	Treatments: age and height appropriate dosage of a NTD specific drug administered to an eligible person in a defined geographic area. Each drug dose is counted as a single treatment such that an individual may receive multiple treatments if treated for multiple diseases and with multiple drugs. The Neglected Tropical Diseases (NTD) targeted by the program are onchocerciasis, schistosomiasis, lymphatic filariasis, trachoma and soil-transmitted helminthes (whipworm, hookworm and roundworm.) The number is specific to the year; a cumulative number can be calculated to provide the treatments delivered since the start of the program.
Linkage to Long-Term Outcome or Impact	The preferred strategy to control and reduce the burden of targeted neglected tropical diseases is preventive chemotherapy (PCT) delivered through mass drug administration (MDA). PCT reduces the infection load and disease burden in individuals. Repeated MDA decreases disease prevalence in communities which leads to a reduction in transmission and thus in incidence. A reduced infection load and disease burden combined with a decrease in disease prevalence and incidence will result in the control and elimination of the targeted neglected tropical diseases as a public health problem. This indicator is for reporting by field OUs. This program is centrally funded and managed; the Global Health Bureau also collects and reports on higher-level indicators for the NTD program reflecting progress towards the GHI targets for NTDs.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	This is a GHI indicator. The indicator is used for program planning, budgeting and reporting. In-country program managers and partners use the indicator for program performance review, drug supply management (including forecasting and ordering drugs from donors and other suppliers) and budgeting.
Data Source and Reporting Frequency	Semi Annual project reports. Data is gathered by drug distributors, who are most often community drug distributors or school teachers. Distributors are trained in drug distribution, record keeping and reporting. Most drugs are taken under direct observation by the distributors.
Known Data Limitations	Standard, internationally accepted data collection and reporting tools are in place and in use. In most settings treatment (drug intake) is observed. As treatments (drugs) are distributed by thousands of community workers, sometimes under hectic circumstances, errors in recording may occur. To reduce errors, regular supervision is conducted by implementing partners in collaboration with national governments. Data are reviewed by implementing partners before reporting.

Baseline Timeframe	Annual data is available starting with FY 2006 for the countries where the NTD initiative has operated.
Disaggregate(s)	Disaggregate by sex. Not gender-sensitive as treatment is delivered following medical criteria, standards and procedures.

Indicator	3.1.5-34 Number of people trained with USG funds in non-Neglected Tropical Diseases, other infectious diseases, and issues of public health importance
Definition	Number of people (medical personnel, health workers, community workers, epidemiologists, teachers, etc.) receiving either pre-service or in-service basic, elementary, technical, or university/certification training of at least one day's duration in non-NTD other infectious diseases treatment, prevention (including vector control) or surveillance. Non-NTD other infectious diseases include dengue and other vector-borne viruses and bacteria, cholera, adult diarrhea, Chagas disease etc. Issues of public health importance include efforts for the containment of antimicrobial resistance, disease surveillance and response (including Field Epidemiology Training Programs), implementation of pharmacovigilance approaches, and the introduction of new diagnostics, prevention, or treatment modalities. NTD: The Neglected Tropical Diseases (NTD) targeted by the program are onchocerciasis, schistosomiasis, lymphatic filariasis, trachoma and soil-transmitted helminthes (whipworm, hookworm and roundworm). Training for these diseases is not included in this indicator.
Linkage to Long-Term Outcome or Impact	Training supports non-NTD other infectious diseases programs because it enables an increased and improved disease surveillance and response, and will facilitate the early detection and mitigation of epidemics. Trainees will be able to conduct disease control and prevention measures and be able to positively influence decision- and policy-makers. Training in the containment of antimicrobial resistance will improve treatment outcomes and reduce costs by preventing the need to change to more expensive second- and third-line antimicrobials. Training in new diagnostics and treatment modalities can make providers more efficient, save money, and improve care. Training community workers also builds community participation and country ownership of programs.
Indicator Type	Output
Unit of Measure	Number of trainees. If a trainee receives training on different subjects, they should be counted as multiple trainees. Annual number, specific to the year.
Use of Indicator	The indicator is used for program planning, budgeting and reporting. In-country program managers and partners use the indicator for program planning and budgeting. As the program matures, many people only need a (shorter) refresher training each year or two.
Data Source and Reporting Frequency	Semi Annual and annual project reports. Data is generally gathered by implementing partners, and the standard for completion of training will be defined in advance. For a short course, full attendance might be the standard; for a longer course, competency testing

	passed; or for certification, a minimum standard.
Known Data Limitations	The data (indicator) provides a timely account of people available for program implementation by representing the number of people trained in program practices and procedures. Mechanisms are in place to reduce possible manipulation of the data. The indicator however does not reflect on the quality of the training provided, nor on the quality of the outcome (e.g. skills acquired) of the training.
Baseline Timeframe	Baseline must be established for each operating unit using the indicator, and so may vary by specific program.
Disaggregate(s)	Disaggregate by sex. Not sex-sensitive, as selection of those to be trained will be based on objective criteria.

Indicator	3.1.5.2-1 Number of consolidated national Non-Communicable Diseases and injury action plans finalized which were developed with USG assistance
Definition	A consolidated national NCDI action plan is national in scope and provides information regarding the nature and magnitude of NCDI problems in the country, priorities for action, and the actions which the government and important professional, charitable, and commercial organizations agree to pursue in a multi-year period. A plan is finalized when it is approved by the planned entities, or published for use. USG assistance may be provided in kind (technical assistance, for example) or by transfer of funds to the government or a participating national organization. Regional operating units might provide USG assistance for more than one such action plan in a given year.
Linkage to Long-Term Outcome or Impact	Proven cost-effective strategies exist to prevent and control NCDIs, but high-level commitment and concrete actions are often missing at the national level. National policy frameworks and action plans are proxies for the priority afforded NCDIs and for the dialogue, commitment and resources essential to addressing the problem.
Indicator Type	Output
Unit of Measure	Number of consolidated national NCDI action plans developed with USG assistance.
Use of Indicator	Reporting that a country has finalized a consolidated national action plan for NCDIs confirms that a country has established or strengthened policies and plans for the prevention and control of NCDIs as an integral part of their national health policy and broader development frame works. The plans can be used by host country governments and organizations, as well as donors to identify, prevent and control those NCDIs (and modifiable risk factors) that most impede development.
Data Source and Reporting Frequency	WHO is developing the capacity to track member states with NCDI action plans? USG will continue to work with WHO to clarify methodology and optimal frequency.
Known Data Limitations	The indicator itself is “either yes or no” per country for a given year and hence does not present a “data limitation” per se. Still the mere existence of an action plan assures neither the quality of that plan nor that the specific actions included in the plans will actually be funded and implemented.
Baseline Timeframe	Baseline needs to be established for each OU using this indicator.
Disaggregate(s)	N/A

Indicator	3.1.5.2-2 Percent of pregnant women who received counseling on the effects of tobacco and smoking in USG-assisted health facilities.
Definition	Of all pregnant women seen in USG-assisted health facilities, the percentage who received counseling on the effects of tobacco and smoking. The numerator is the number of pregnant women who received counseling on tobacco and smoking in USG-assisted health facilities. The denominator is the total number of pregnant women receiving health services in USG-assisted health facilities.
Indicator Type	Output
Unit of Measure	Percent of women counseled This number is specific to the program year.
Use of Indicator	Health systems in most lower and middle income countries are focused on critical and infectious disease care and ill-suited to provide effective NCDI services. This indicator will help measure the NCDI services offered to pregnant women through health facilities. Since this indicator is applied to one of the most cost-effective interventions and to traditional target groups for donor assistance, a low percentage suggests a lack of commitment of capacity to address tobacco issues, one of the most significant causes of preventable mortality and morbidity.
Data Source and Reporting Frequency	• Annual review of project data; • Confirmation via periodic chart reviews, focus groups and/or surveys.
Known Data Limitations	In low resources settings, it can be challenging to make an unduplicated count of patients who visit multiple times during the year, as prenatal patients normally do. It is not easy to accurately verify interactions between patients and providers. Project data should be verified with special periodic reviews and surveys. USG funded projects involving NCDIs should expect increases in this indicator over time, as such counseling becomes the norm for prenatal care.
Baseline Timeframe	Baseline needs to be established by each OU using this indicator.
Disaggregate(s)	N/A

Indicator	3.1.5.2-3 Number of USG assisted service delivery points offering a basic package of Non Communicable Disease and Injury (NCDI) prevention and control services
Definition	The number of USG assisted health facilities, regardless of size or location, offering a pre-defined basic package of NCDI services. Illustratively, such services could include cervical cancer screening and treatment, clinical breast exams, screening and brief interventions for smoking and /or alcohol abuse, or screening for hypertension or domestic violence.
Linkage to Long-Term Outcome or Impact	Along with population-based public health interventions, proven, cost-effective clinically based interventions may be needed to promote prevention and early diagnosis and management among most at-risk populations of NCDIs – all of which contribute to reduced mortality and morbidity and cost savings to the family and society.
Indicator Type	Output
Unit of Measure	Number Specific to program year; for facilities that start or stop providing such services during the program year, count those providing services at the close of the year.
Use of Indicator	Health systems in most lower or middle-income countries are focused on critical and infectious disease care and ill-suited to provide effective NCDI services. This indicator will help measure the range and breadth of NCDI services offered through the health system.
Data Source and Reporting Frequency	• Annual review of project data; • Confirmation via periodic chart reviews and/or surveys.
Known Data Limitations	The indicator itself is “either yes or no” and hence does not present a “data limitation” per se. Still, offering an NCDI service assures neither the quality of that specific service nor that the facility is able to address the range of NCDI problems that may present.
Baseline Timeframe	Baseline needs to be established for each OU reporting on this indicator.
Disaggregate(s)	N/A

3.1.6 – Maternal and Child Health

Indicator	3.1.6.1-1 Percent of births attended by a skilled doctor, nurse or midwife¹
Definition	Numerator: Births in a given year attended by a skilled birth attendant (SBA) such as a doctor, nurse, or midwife¹ Denominator: Live births in the same year/100 ¹A doctor, midwife or nurse is a person who, having been regularly admitted to a professional educational program, is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies and has acquired the requisite qualifications to be registered and/or legally licensed to practice.
Linkage to Long-Term Outcome or Impact	Most non-abortion-related maternal deaths happen during labor and delivery or within the first few days following birth. Potentially fatal complications occur among women who do not fall into any of the traditional high-risk groups and are therefore difficult to predict and/or prevent. In many countries births occur at home. Increasing the frequency of attendance of skilled birth attendants is considered by the global public health community to be a necessary component of maternal and newborn services to decrease maternal and neonatal mortality and morbidity since many of the proven interventions, such as active management of the third stage of labor, can normally only be provided by skilled birth attendants.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	This indicator is used by planners and managers to identify and target geographic areas for care, when disaggregated sub-nationally, and to indicate areas of need in relation to preparation, deployment and retention of personnel. It can be used for policy discussion to develop context specific strategies to improve care for childbearing women during labor and birth. This indicator in and of itself does not measure quality of care and so it should be assessed along with other indicators.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	There may not be consistency in identifying trained personnel by survey respondents. They may not know the basic credential of the provider in some cases. Surveys such as the DHS do not identify doctors and nurses with midwifery training/skills. Some surveys identify assistance from a skilled provider but do not specify their actual qualifications.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Wealth Quintile (lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm; Numerator, Denominator

Indicator	3.1.6.2-1 Percent of births delivered by caesarean section
Definition	Numerator: Births delivered by caesarean section Denominator: Live births /100
Linkage to Long-Term Outcome or Impact	This indicator reflects the availability, accessibility and utilization of emergency obstetric care which is directly linked to birth outcome for mothers and fetuses who encounter life-threatening complications during pregnancy and birth. Not all Cesarean sections are done for medical indications. Levels that are too high, as well as too low, are associated with adverse outcomes, including death. The consensus of experts is that the best range of population-based Cesarean sections rate is 5-15%, but there is no evidence for the ideal Cesarean sections rate which is context specific related to a number of factors, including the type of facility; referral facilities should have higher rates than non-referral facilities.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Promote appropriate use of Cesarean sections as a marker of emergency care for obstetric complications with emphasis on the provision of care in accordance with evidence-based standards. Where population-based Cesarean sections rate is greater than 15%, there needs to be careful assessment of whether there has been appropriate indication. Where Cesarean sections is <5%, efforts should be made to increase appropriate use to no more than 15%.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey). DHS surveys are country-specific and published every 3-5 years. Operating units will decide whether to use DHS or a country-level study for reporting purposes. DHS: http://www.measuredhs.com/countries/ Individual operating units will input data during years when new data is available.
Known Data Limitations	Overall data quality is good, since respondents can easily identify delivery through Cesarean -section.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.6.1-2 Percent of births receiving at least 4 antenatal care (ANC) visits during pregnancy
Definition	Numerator: The number of women who received at least 4 ANC visits during the latest pregnancy during a specified time period, such as month or year. Denominator: The total number of women who had a live birth in the same specified period/100
Linkage to Long-Term Outcome or Impact	This indicator is based on evidence from a WHO systematic review of randomized trials that resulted in a recommendation of 4 ANC visits to women for basic antenatal care.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Information used both for program planning and adjustments. Data is segregated by region and wealth, quintiles to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners
Data Source and Reporting Frequency	DHS (Demographic and Health Survey). DHS surveys are country-specific and published every 3-5 years. Operating units will decide whether to use DHS or a country-level study for reporting purposes. DHS: http://www.measuredhs.com/countries/ Individual operating units will input data during years when new data is available.
Known Data Limitations	Data may not be strictly comparable. Recall error is likely on number of ANC visits.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.6-58 Maternal Mortality Ratio (MMR)
Definition	Maternal deaths in women aged 15-49 years that occurred during pregnancy, delivery or within two months of delivery. Numerator: Maternal deaths in women aged 15-49 years that occurred during pregnancy, delivery or within two months of delivery Denominator: The number of live births. The number of live births is used in the denominator as an approximation of the population of all pregnant women who are at risk of a maternal death.
Linkage to Long-Term Outcome or Impact	A major outcome of GHI will be to improve maternal mortality. This is consistent with MDG 5.
Indicator Type	Impact
Unit of Measure	Per 100,000 live births
Use of Indicator	This indicator used to measure progress towards Millennium Development Goal (MDG) 5. The indicator will be used for program planning and adjustments and to decide whether budget allocation needs to change for desired impact. This indicator will be used by policy makers, program managers, and development partners.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) and Reproductive Age Mortality Survey (RAMOS) studies. DHS surveys are country-specific and published every 3-5 years. RAMOS studies are country-specific. Operating units will decide whether to use DHS, RAMOS, or a country-level study for reporting purposes. DHS: http://www.measuredhs.com/countries/ Individual operating units will input data during years when new data is available.
Known Data Limitations	Ideally, data is retrieved through a vital registration system. In the vast majority of countries with high maternal mortality this is not possible and surveys are utilized. Maternal mortality rates and ratios are subject to high levels of relative sampling error due to their relatively rare occurrence. Given that maternal deaths are relatively rare events, obtaining MMRs with reasonably good precision requires extremely large samples, particularly where fertility is not exceptionally high. Except where sample sizes are extremely large, MMRs calculated from large DHS-type surveys relate to a time up to ten years prior to the survey date, meaning that the “current” ratio will in fact be several years old, a potential drawback in using MMR as a measure of recent change. Maternal mortality is also affected by non-health social determinants. Nevertheless, maternal mortality ratios are more robust, easier to measure, and better reflect obstetric risk than maternal mortality rates. Conventionally, they have been tracked longitudinally for longer periods of time approximately 5 years. While RAMOS studies can be considered more accurate, they tend to be extrapolated from studies on subnational populations, DHS provides trend data though with less accuracy.

Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	None

Indicator	3.1.6.4-1 Percent of children who received DPT3 vaccine by 12 months of age
Definition	Numerator: Children 12-23 month of age who received third dose of DPT (Diphtheria, Pertussis, Tetanus)-containing vaccine by 12 months of age. Denominator: Number of living children age 12-23 months/100
Linkage to Long-Term Outcome or Impact	Coverage of child immunization through regular programs, rather than special campaigns, is an internationally accepted health indicator because it improves overall immunization status, as well as being a good indication of a working health system and utilization of services.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	Information used both for program planning, program adjustment and budget decisions. Data is segregated by region, quintile to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners.
Data Source and Reporting Frequency	Most recent DHS/MICS/Reproductive Health Survey and other population based surveys. DHS (Demographic and Health Survey) surveys and MICS (Multiple Indicator Cluster Survey) are country-specific and published every 3-5 years: • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Coverage data is routinely reported by UNICEF and WHO and this serves as the primary source for all reporting purposes. In most countries data is collected and reported on an annual basis. Local data reports are available at greater frequency but they are not routinely collected across all countries. Special surveys may be conducted, however most coverage data is administrative data. Individual operating units will input data during years when new data is available.
Known Data Limitations	Data quality often depends on recall by respondents (since almost half of respondents are unable to produce the immunization record cards at the time of the survey).
Baseline Timeframe	The year in which baseline data is collected for this indicator varies by operating unit
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.4-2 Percent of children who receive the third dose of haemophilis influenza B vaccine (Hib3) by age 12 months
Definition	Numerator: Children who received three doses of haemophilis influenza B vaccine (Hib3) by 12 months of age. Denominator: Number of living children age 12-23 months/100
Linkage to Long-Term Outcome or Impact	Immunization is a proven cost-effective intervention that annually averts 2.5 million deaths among children under age 5. Each year, immunization programs reach more than 100 million children under age 1, protecting them against common childhood diseases such as Hib3.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	Information used both for program planning and adjustments. Data is segregated by region, quintile to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners
Data Source and Reporting Frequency	Most recent DHS/MICS/Reproductive Health Survey and other population based surveys. DHS (Demographic and Health Survey) surveys and MICS (Multiple Indicator Cluster Survey) are country-specific and published every 3-5 years: • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Coverage data is routinely reported by UNICEF and WHO and this serves as the primary source for all reporting purposes. In most countries data is collected and reported on an annual basis. Local data reports are available at greater frequency but they are not routinely collected across all countries. Special surveys may be conducted, however most coverage data is administrative data. Individual operating units will input data during years when new data is available.
Known Data Limitations	HiB is typically given as part of pentavalent (or hexavalent) vaccine. Demographic Health Survey(DHS) includes pentavalent only as an alternate to DPT. Data quality depends on recall by respondents (since almost half of respondents are unable to produce the immunization record cards at the time of the survey).
Baseline Timeframe	The year in which baseline data is collected for this indicator varies by operating unit
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.4-3 Percent of children who have received the third dose of Pneumococcal conjugate vaccine by 12 months of age
Definition	Numerator: Number of children who have received the third dose of Pneumococcal conjugate vaccine by 12 months of age Denominator: Number of living children age 12-23 months
Linkage to Long-Term Outcome or Impact	According to UNICEF, the pneumococcal conjugate vaccine (PCV) and rotavirus vaccine (RV) protect against the leading causes of pneumonia and diarrhea, respectively. By themselves, these vaccines could save about 1 million children's lives every year, sharply increasing the 2.5 million under-five deaths currently prevented through immunization annually.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	The information will primarily be used by program managers and policy makers to assess program effectiveness and forecast commodity needs as well as plan for expanded outreach services to underserved areas.
Data Source and Reporting Frequency	Most recent DHS/MICS/Reproductive Health Survey and other population based surveys. DHS (Demographic and Health Survey) surveys and MICS (Multiple Indicator Cluster Survey) are country-specific and published every 3-5 years: • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Coverage data is routinely reported by UNICEF and WHO and this serves as the primary source for all reporting purposes. In most countries data is collected and reported on an annual basis. Local data reports are available at greater frequency but they are not routinely collected across all countries. Special surveys may be conducted, however most coverage data is administrative data. Individual operating units will input data during years when new data is available.
Known Data Limitations	Immunization coverage data has been collected by national authorities over the last 25 years. There is a wide range in accuracy and timeliness. In most cases the data is as accurate as population estimates of information such as number of live births would allow. It is very difficult to validate administrative coverage figures as survey data often relies on maternal recall of vaccination and the margin of error in that process is very high. What one often looks for in coverage data is trends, as opposed to absolute levels, and that tends to cancel out consistent biases so that the data becomes much more reliable. While the reporting can always be improved a certain amount of error will always be present in coverage data.
Baseline Timeframe	The year in which baseline data is collected for this indicator varies by operating unit
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.4-4 Percent of children 12-23 months of age who have received measles vaccine by 12 months of age
Definition	Numerator: Children age 12-23 months of age who received measles vaccine by the time they were 12 months of age Denominator: Number of living children age 12-23 months/100
Linkage to Long-Term Outcome or Impact	Coverage of child immunization through regular programs, rather than special campaigns, is an internationally accepted health indicator because it improves overall immunization status, as well as being a good indication of a working health system and utilization of services. Targeted vaccination campaigns have had a major impact on reducing measles deaths.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Indicator will be used for program planning and adjustments; to decide whether budget allocation needs to change for desired impact. Used by policy makers, program managers and development partners
Data Source and Reporting Frequency	Most recent DHS/MICS/Reproductive Health Survey and other population based surveys. DHS (Demographic and Health Survey) surveys and MICS (Multiple Indicator Cluster Survey) are country-specific and published every 3-5 years: • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Coverage data is routinely reported by UNICEF and WHO and this serves as the primary source for all reporting purposes. In most countries data is collected and reported on an annual basis. Local data reports are available at greater frequency but they are not routinely collected across all countries. Special surveys may be conducted, however most coverage data is administrative data. Individual operating units will input data during years when new data is available.
Known Data Limitations	Data quality depends on recall by respondents (since almost half of respondents are unable to produce the immunization record cards at the time of the survey).
Baseline Timeframe	The year in which baseline data is collected for this indicator varies by operating unit
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.5-1 Rate of non-polio acute flaccid paralysis (AFP) cases occurring per 100,000 children less than 15 years of age (non-polio AFP rate)
Definition	The rate of non-polio acute flaccid paralysis cases occurring per 100,000 children less than 15 years of age. Numerator: Number non-polio cases (number of acute flaccid paralysis cases reported, detected, investigated, samples collected and analyzed in a WHO accredited laboratory and determined to be caused by something [virus, condition, disease] other than the polio virus.) Denominator: per 100,000 children under age 15
Linkage to Long-Term Outcome or Impact	In order for countries to be certified polio free, they must be able to prove they have had no lab confirmed polio cases for a minimum of 3 years. Our goal is to certify the world is polio free. Conditions other than polio can cause paralysis and this occurs at a background rate of about 2/100,000 in children under age 15. A sensitive, certification-standard polio surveillance system will be able to detect these non-polio cases. The assumption is, that if we are finding all of the non-polio paralysis cases, we would find polio if it was circulating. To qualify for certification, countries have to maintain a non-polio AFP rate for a minimum of 3 years and then until global certification. [Finding zero paralysis cases caused by polio is an indication that the immunization campaigns are working. A greater portion of USAID funds is targeted at surveillance rather than immunization campaigns.]
Indicator Type	Outcome
Unit of Measure	Rate
Use of Indicator	This indicator is used to determine the sensitivity of the polio surveillance system at the national level. The surveillance system should find a minimum of 2 non-polio AFP cases per 100,000 children less than 15 years of age. This is the key indicator for global certification of polio-free status.
Data Source and Reporting Frequency	WHO This data is reported weekly to WHO. Every country has dedicated surveillance officers and a network of weekly reporting sites who search for polio cases in every community of the developing world. Cases of acute (rapid onset) flaccid (floppy) paralysis (AFP) are reported to the surveillance officer, who investigates within 24 hours. 2 stool samples are collected (24 – 48 hours apart) and transported, in a reverse cold chain, to an accredited laboratory, where it takes 14 days to complete the analysis. Laboratory results indicating whether the paralysis was caused by polio or non-polio are reported back to countries and WHO on a

	weekly basis. If it is polio, the lab will also indicate which type (1,2 or 3) of virus was isolated and if it is wild or vaccine-derived. Data are published and disseminated in country, regional and global updates on a weekly basis. It is the only surveillance system in the world with near-real-time data collection and analysis on a global scale.
Known Data Limitations	Polio surveillance has been active since the late 1980's in most countries. Countries undergo desk and external field surveillance reviews to identify gaps and weaknesses. There are a series of standardized process indicators (zero-case reporting, identification of silent areas) and other lab tests (e.g. the non-polio enterovirus rate; environmental sampling) to confirm the quality of the surveillance system. There are other indicators to track the transportation time from child to the lab and sample adequacy, shipping conditions. There is an annual independent accreditation process for the 148 labs in the polio network where labs need to correctly identify "mystery" samples in proficiency panels. There have been a few instances of countries trying to hide cases, but these have been easy to identify and there are systems in place for corrective action. The number of annual expected cases and actual cases are tracked on a weekly basis, data are reviewed to identify silent areas and corrective action taken. Overall this is one of the most valid, reliable, precise and timely indicators in use in public health today.
Baseline Timeframe	The polio system has data going back at least 15 years, but this indicator does not use a baseline – we are not looking for year to year incremental change – but looking for a condition that occurs at a predictable level across countries.
Disaggregate(s)	None

Indicator	3.1.6-60 Newborn Mortality Rate
Definition	Numerator: Number of deaths among infants in the first 28 days of life in a given year Denominator: Number of live births in that year/1000
Linkage to Long-Term Outcome or Impact	Reducing the neonatal mortality rate (NMR) directly contributes to MDG 4, to reduce under-five child mortality by two-thirds between 1990 and 2015. Mortality among children in the first month of life is responsible for 37 percent of under-five mortality (WHO 2008).
Indicator Type	Impact
Unit of Measure	Per 1,000
Use of Indicator	The indicator will be used for program planning and adjustments and to decide whether budget allocation needs to change for desired impact. This indicator will be used by policy makers, program managers, and development partners.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. - DHS: http://www.measuredhs.com/countries/ - MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	Often disaggregated neonatal mortality rates are presented for 10-year periods because of the rapid increase in sampling error if multiple categories are used. Censuses and surveys provide such detail; vital registration data usually does not include socio-economic variables but can provide the other disaggregations. However, in most of the developing world VR is of little or no value in looking at child mortality because of extreme incompleteness of both numerators and denominators Age-specific mortality rates are calculated from data on births and deaths in vital statistics registries, censuses and household surveys in developing countries. Estimates based on household surveys data are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). The data are then summed for neonates, and the results are expressed as a rate per 1,000 live births. Because rates calculated from DHS-type surveys relate to a time several years prior to the survey date, the “current” ratio may in fact be several years old, a potential drawback in using NNMR as a measure of recent change.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Sex

Indicator	3.1.6.7-1 Percent of children under five years old with diarrhea treated with Oral Rehydration Therapy (ORT)
Definition	Numerator: Children under five years of age with diarrhea, who received oral rehydration therapy (ORT), defined as receiving Oral rehydration solution (ORS), Recommended Home Fluids (RHF) or increased fluids. Denominator: Children under five years of age who were ill with diarrhea in the two weeks preceding the survey/100.
Linkage to Long-Term Outcome or Impact	Proper treatment of diarrhea contributes to MDG 4, to reduce under-five child mortality by two-thirds between 1990 and 2015. Diarrhea is a leading cause of death among children under age 5. Despite the availability of effective, low-cost prevention and management interventions such as ORT, diarrhea causes more than 1.5 million child deaths each year and is also a substantial contributor to child malnutrition. According to UNICEF, each year an estimated 2.5 billion cases occur among under-5 children, with more than half occurring in Africa and South Asia. These two regions also account for more than 80 percent of diarrhea-related child deaths – just 15 countries account for almost three-quarters of these deaths.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Information used both for program planning and, program adjustment. Data is segregated by sex, region and wealth, quintiles to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	Alternate ORT definitions from DHS or UNICEF may include ORS or RHF or ORH/RHF and increased fluids. The UNICEF definition is defined as receiving ORS, RHF or increased fluids and increased feeding. ORT data are also available in MICS reports. However, ORT data are not available in MICS I and most MICS II and MICS III surveys use the UNICEF definition which includes increased feeding.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.7-2 Percent of children with pneumonia taken to appropriate care
Definition	Numerator: Children under five years of age with Acute Respiratory Infection (ARI) symptoms for whom care was sought from a health facility or provider Denominator: Children under five years of age who were ill with an acute respiratory infection (ARI), exhibiting symptoms of cough with rapid breathing, during the two weeks preceding the survey/100
Linkage to Long-Term Outcome or Impact	Proper treatment of ARI contributes to MDG 4, to reduce under-five child mortality by two-thirds between 1990 and 2015. ARI is a leading cause of death among children under age five. Every year, an estimated 150 million or more episodes of pneumonia occur in young children in developing countries. These pneumonia cases account for more than 95 percent of all new cases globally, and more than half of them occur in South Asia and sub-Saharan Africa. Between 11 million and 20 million of the affected children require hospitalization, and more than 2 million die worldwide. Approximately 60 percent of pneumonia cases in developing countries are caused by bacteria that can be treated with antibiotics, but fewer than 20 percent of children get antibiotics in time.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	Information used both for program planning and adjustment. Data is segregated by sex, region, and wealth quintiles to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	In select reports, the data for treatment of ARI and fever are combined. As ARI is typically used as a proxy for pneumonia, while fever is used as a proxy for malaria, combining the two creates a different indicator. If a treatment of ARI and/or fever number is used rather than treatment for ARI only, there should be a footnote. A “health facility or provider” does not include traditional practitioners, pharmacies, or other shops.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.6.3-1 Percent of newborns receiving postnatal health check within two days of birth
Definition	Numerator: Number of newborns that received a postnatal care check within 2 days after delivery Denominator: Total number of live births
Linkage to Long-Term Outcome or Impact	The indicator is important given the crucial role of the postnatal period for newborn survival and health. Three-quarters of newborn deaths occur during first week of life – with half concentrated in the first day. Postnatal care checks serve as a platform from which a variety of services can be delivered and key practices encouraged. Postnatal checks can be effectively provided both in health facilities by skilled providers as well as by trained community-based workers. Available evidence demonstrates that the timing of the postnatal care is important. Earlier postnatal care visits are more effective in preventing neonatal mortality and improving healthy behaviors. This recognition led to an adjustment in the postnatal care indicator with the measure now focused on visits within two days compared to three.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	Information used both for program planning and adjustments. Data is segregated by region and wealth quintiles to indicate whether targeted programming is needed. Data used by in-country program managers (public and non-public sectors), policy makers, development partners
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. • DHS: http://www.measuredhs.com/countries/ • MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	Respondents may have problems understanding what constitutes post-natal checkup. Also, some check-ups may be by traditional birth attendants, who are not trained for post natal checkups.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.6-54 Under Five Mortality Rate (U5MR)
Definition	Numerator: Number of deaths among children under age five in a given year Denominator: Number of live births in the same year/1000
Linkage to Long-Term Outcome or Impact	Under-5 mortality rate is a leading indicator of the level of child health/survival and overall development in countries. It also reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care. Because data on the incidences and prevalence of diseases (morbidity data) frequently are unavailable, mortality rates are often used to identify vulnerable populations. The under-five mortality rate captures more than 90 percent of global mortality among children under the age of 18. It is a key indicator for Global Health Initiative (GHI) as well as being the indicator to measure Millennium Development Goal (MDG) 4: reduction of child mortality.
Indicator Type	Impact
Unit of Measure	Per 1,000 live births
Use of Indicator	The indicator will be used for program planning and adjustments and to decide whether budget allocation needs to change for desired impact. This indicator is also used to measure progress towards MDG 4. This indicator will be used by policy makers, program managers, and development partners.
Data Source and Reporting Frequency	DHS (Demographic and Health Survey) or MICS (Multiple Indicator Cluster Survey). DHS and MICS are country-specific and published every 3-5 years. Operating units will decide whether to use DHS/MICS or a country-level study for reporting purposes. - DHS: http://www.measuredhs.com/countries/ - MICS: http://www.unicef.org/statistics/index_24302.html Individual operating units will input data during years when new data is available.
Known Data Limitations	Under-five mortality rate is strictly speaking, not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1000 live births. Often disaggregated under-5 mortality rates are presented for 10-year periods because of the rapid increase in sampling error if multiple categories are used. Censuses and surveys provide such detail; vital registration data usually does not include socio-economic variables but can provide the other disaggregations. However, in most of the developing world VR is of little or no value in looking at child mortality because of extreme incompleteness of both numerators and denominators. Age-specific mortality rates are calculated from data on births and deaths in vital statistics registries, censuses and household surveys in developing countries. Estimates based on household surveys data are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). The

	data are then summed for children under five, and the results are expressed as a rate per 1,000 live births. Because rates calculated from DHS-type surveys relate to a time several years prior to the survey date, the “current” ratio may in fact be several years old, a potential drawback in using U5MR as a measure of recent change.
Baseline Timeframe	The year in which baseline data is collected for this indicator is determined by individual operating units.
Disaggregate(s)	Sex

Indicator	3.1.6.8-1 Percent of households with soap and water at a handwashing station commonly used by family members
Definition	A handwashing station is a location where family members go to wash their hands. In some instances, these are fixed locations where handwashing devices are built in and are permanently placed. But they may also be movable devices that may be placed in a convenient spot for family members to use. The measurement takes place via observation by an enumerator during the household visit. The enumerator must see the soap and water at this station. The soap may be in bar, powder, or liquid form. Shampoo will be considered liquid soap. The cleansing product must be at the hand washing station or reachable by hand when standing in front of it. A “commonly used” handwashing station, including water and soap, is one that can be readily observed by the enumerator during the household visit, and where study participants indicate that family members generally wash their hands. Numerator: number of households where both water and soap are found at the commonly used handwashing station Denominator: total number of households
Linkage to Long-Term Outcome or Impact	A clear link can be made between handwashing with soap among child caretakers at critical junctures and the reduction of diarrheal disease among children under five, one of the two major causes of child morbidity and mortality in developing countries. The critical junctures in question include handwashing with soap after the risk of fecal contact (after defecation and after cleaning a child’s bottom) and before handling food (before preparing food, eating, or feeding a child).
Indicator Type	Outcome
Use of Indicator	Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness.
Data Source and Reporting Frequency	Round 4 of Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF (http://childinfo.org/mics4.html , tab Surveys), the Demographic and Health Surveys (DHS) Macro (http://www.measuredhs.com/countries/) and household surveys, which may be conducted in project areas at least twice during USG-funded interventions.. Cognizant Technical Officers (CTOs) and Agreement Officer Technical Representative (AOTRs) must seek this information from contractors implementing USG funded interventions.
Known Data Limitations	The measurement of handwashing is difficult and should preferably be conducted by objective measures that do not rely on self reports. Spot checks required to obtain information are an objective proxy for measuring handwashing. A study conducted in India tested the validity of different hand washing indicators. The reference for this study is: Biran, A., T. Rabie, W. Schmidt, S. Juvekar, S. Hirve, V. Curtis. (2008). See also, “Comparing the performance of indicators of handwashing practices in rural Indian households.” <i>Tropical Medicine and International Health</i> . Vol. 13, No. 2, pp. 278-285. In this study, 27 measures were compared to what

	is believed to be the gold standard for hand washing measurement: structured observations. Using the 27 measures, the study attempted to predict whether individuals were washers or non-washers as defined via structured observation. The results indicated an ability to predict the non-washers but were inconclusive about predicting the washers. The indicator associated with prediction of non-washers was the lack of soap in different locations in the household, including the yard. If there is no soap at a handwashing station, then no handwashing with soap will ever occur. Consequently, checking to see if soap is present at handwashing stations is a simple and important indicator. Water is obviously needed to wash hands and the quality of water is not important and may not be detected through the survey. In some contexts, soap may be an expensive commodity and family members may carry the soap to the handwashing station when they want to wash their hands, in order to prevent theft of the soap or misuse. However, it is assumed that the visible presence of soap at a hand washing station acts as a cue and, thus, as a reminder that it needs to be used at critical junctures. When conducting the analysis, program managers and evaluators may decide to cross the information about the presence of water at handwashing stations with the presence of soap anywhere in the house (in households with no observable soap at a handwashing station). In such instances: the presence of water plus soap at the most commonly used handwashing station and the presence of water at the same location plus the presence of soap elsewhere in the house may be reported separately.
Baseline Timeframe	A baseline needs to be established for each project the first year for which data is collected for this indicator will vary for each operating unit. Since this is an indicator that both DHS and MICS collect, published data obtained through these surveys may also be used, if applicable, in target areas for USG programs.
Disaggregate(s)	Disaggregate by rural and urban households and by wealth quintile (lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm Disaggregation will need to be provided by DHS and/or contractors implementing USG-funded interventions; Numerator, Denominator

Indicator	3.1.6.8-2 Percent of households in target areas practicing correct use of recommended household water treatment technologies
Definition	Measures of correct use are objective and rely for the most part on observations or a specific chemical test, depending on the water treatment technology used. Those technologies are chlorination, filtration, solar disinfection, or boiling. Chlorine residual testing is required for chlorination; observation of functioning filters is required in the case of filtration; observation of bottles with water exposed to the sun is required in the case of solar disinfection; and specific questions regarding the container used to boil and duration of boiling are required for boiling. Households will be considered to be correctly practicing water treatment technologies if the following conditions are met for any of the treatment options: • Chlorination: an enumerator carrying out the chlorine residual test obtains positive results (CT+); • Filtration: enumerators are able to see the filter and verify that water is in the filter's bottom container or comes out of the filter's tap (Filter +); • Solar disinfection: the enumerator is able to see that bottles filled with water are exposed to the sun and self reports by study participants indicate that bottles are exposed to the sun for at least six hours per day of exposure (SODIS+) on sunny days and up to two days on cloudy days; • Boiling: study participants report that boiling occurred until water comes to a rolling boil and the same container where water is boiled is used to store boiled water (BOIL+). Numerator: Number of households with CT+ or SODIS+ or Filter+ or BOIL + Denominator: Total number of households visited
Linkage to Long-Term Outcome or Impact	The World Health Organization (WHO) argues that about 88 percent of diarrheal cases worldwide are attributable to unsafe water, inadequate sanitation, or insufficient hygiene. WHO also argues that the majority of those cases are due to the consumption of drinking water contaminated by bacterial, viral, or protozoan pathogens. The organization estimates that "low cost interventions for household-based treatment of drinking water and safe storage can significantly reduce the pathogen load in drinking water and . . . reduce the risk of diarrheal disease." In 2009, UNICEF and WHO adopted a comprehensive strategy for effective diarrhea control that includes household water treatment and safe storage as proven interventions to reduce child mortality.
Indicator Type	Outcome
Use of Indicator	Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness. The information will also be used to make funding allocations.
Data Source and Reporting Frequency	Surveys collected in project areas that might be conducted at least twice during USG-funded interventions.

Known Data Limitations	The questions used to measure this indicator observe or infer the performance of the practice, relying only exceptionally on self-reports. Families may use more than one method. If so, the calculations would have to take this into account and adjust accordingly. Boiling will remain the more challenging treatment method to measure. Measurements included here reflect the Centers for Disease Control (CDC) recommendations regarding boiling as described in their 2009 publication entitled <i>Household Water Treatment Options in Developing Countries: Boiling</i>. Fact Sheet. And available at http://www.hip.watsan.net/page/3216. Training of enumerators will be particularly important to ensure proper use of suggested questions for this indicator. Chlorine residual testing is required for those that practice chlorination. The SODIS indicator proposed here focuses on the practice of solar disinfection, not on determining whether bottles used for this purpose have been cleaned prior to their use.
Baseline Timeframe	A baseline needs to be established for each intervention. The first year for which data are collected for this indicator will vary for each operating unit.
Disaggregate(s)	Break down by technology, residence (urban and rural), and socioeconomic quintiles, if possible. This breakdown will be requested of contractors implementing USG funded interventions; Numerator, Denominator

Indicator	3.1.6.8-3 Percent of population in target areas practicing open defecation
Definition	Open defecators are individuals who live in households that have no sanitation facility and who declare there is no sharing of sanitation facilities with any other household. When asked what sanitation facility the family uses, they answer by saying that they defecate in the bush, in open fields, or other open spaces. Numerator: number of households indicating that they do not use sanitation facilities or share anybody else's facilities Denominator: total number of households in the survey
Linkage to Long-Term Outcome or Impact	For sanitation coverage purposes, the water, sanitation, and hygiene (WASH) sector divides households into three large categories: open defecation, unimproved sanitation, and improved sanitation. These categories are used to define a sanitation ladder. The WASH sector seeks to have households move up the sanitation ladder and eventually arrive at improved sanitation in order to meet sanitation-related Millennium Development Goals (MDGs). An increase in the percentage of households that abandon open defecation is an indication that there is movement toward reaching the sanitation-related MDGs in the expected direction.
Indicator Type	Outcome
Use of Indicator	Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness. The information will also be used to make funding allocations and report on the extent to which USG assistance is helping countries move in the right direction to meet sanitation-related MDGs.
Data Source and Reporting Frequency	Multiple Indicator Cluster Surveys (MICS), Demographic and Health Surveys (DHS) and household surveys that may be collected in project areas at least twice during USG-funded interventions by project implementers.
Known Data Limitations	Data are collected two ways: through self-reports and then through verification when enumerators ask household to see the facilities.
Baseline Timeframe	A baseline needs to be established for each intervention. Since this is an indicator that both DHS and MICS collect, published data obtained through these surveys may also be used, if applicable, because data collection occurred in target areas for USG-assisted projects.
Disaggregate(s)	Break down by residence (urban and rural) and socioeconomic quintiles, if possible. Disaggregation will need to be provided by contractors implementing USG-funded interventions; Numerator, Denominator

Indicator	3.1.6.8-4 Number of liters of drinking water disinfected with point-of-use treatment products as a result of USG assistance
Definition	Liters of drinking water treated with one or more USG-supported proven methods for point-of-use disinfection
Linkage to Long-Term Outcome or Impact	Disinfecting and properly storing drinking water at the household level is associated with a 34 percent reduction in diarrheal disease prevalence among young children as suggested by the following study: Fewtrell, et al. (2005) "Water, sanitation and hygiene interventions to reduce diarrhoea in less developed countries: a systematic review and meta-analysis." <i>The Lancet</i> , 5: 42-52. It is among the most cost-effective water, sanitation, and hygiene (WASH) interventions from a public health perspective.
Indicator Type	Output
Unit of Measure	Liters treated calculated based on the number of chlorine-based products sold and the amount (in liters) that may be treated with each product.
Use of Indicator	Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness. Data may be obtained annually and accrued across countries.
Data Source and Reporting Frequency	Product sales obtained from implementing partners; cooperating public, commercial, and not-for-profit agencies.
Known Data Limitations	Sales of a product do not guarantee that individuals buying it will use it correctly.
Baseline Timeframe	A baseline may be collected as soon as USG-funded assistance is initiated. The first year for which data is collected for this indicator will vary for each operating unit.
Disaggregate(s)	None

Indicator	3.1.6.8-5 Number of communities certified as “open defecation free” (ODF) as a result of USG assistance
Definition	The Handbook on Community Led Total Sanitation produced by Kamal Kar and Robert Chambers in 2008 suggests a qualitative approach to determining open defecation free status. This may include: visiting former open defecation sites at dawn and dusk, determining whether open/hanging latrines are being used as well as paths to installed latrines, and observing existing community sanctions for infringements to ODF rules, etc. To facilitate inspection and safeguard against fraud when rewards to communities are used as incentives, verification of ODF may require involving a committee of inspectors made up of government officials, NGO staff, community residents, and residents from neighboring towns that have achieved ODF status. Kar and Chambers even suggest withholding certification of ODF status for a six-month period to ensure that sanitation coverage has been sustained. Qualitative methods, such as those mentioned above, may also be combined with quantitative measures. Households in a village labeled as ODF may be visited to count how many households in the village have a latrine. This may also be achieved through a mapping exercise.
Linkage to Long-Term Outcome or Impact	Poor access to adequate sanitation will result in the practice of open defecation. The Water and Sanitation Program at the World Bank argues that three harmful impacts may result from open defecation: the spread of diarrheal disease, loss of privacy and human dignity, and environmental pollution. A rapid assessment in Himachal Pradesh revealed that in villages with around 30 percent household toilet use, the incidence of diarrhea was reported as being around 40 percent. Even in villages where 95 percent of households used toilets, diarrheal incidence was still reported to be around 25 percent. Only ODF villages with 100 percent toilet usage have reported a significant drop in diarrhea to less than 10 percent. The key finding is that even if a few households continue to practice open defecation, the overall risk of bacteriological contamination and incidence of disease may continue to be high. This information was reported by Sanan, D. and S. G. Moulik. (2007). Community Led Total Sanitation: An Approach that Works. New Delhi: Water & Sanitation Program.
Indicator Type	Output
Unit of Measure	Communities
Use of Indicator	Information to be used by cooperating agencies and contractors implementing programs to report on project performance. Data may be used to modify interventions to increase effectiveness.
Data Source and Reporting Frequency	Data collected by national government and implementing partners on USG-assisted communities at least twice during project implementation.
Known Data Limitations	Program managers may be interested in using a Community-Led Total Sanitation (CLTS) approach to increase sanitation coverage. A recent review conducted by Sijbesma of experience with CLTS has indicated that

	health outcomes will depend on toilet cleanliness and maintenance and other hygiene practices including handwashing with soap at critical moments and appropriate treatment and storage of drinking water at the point of use. That review also suggests: leaders may have coerced households to engage in CLTS by imposing fines on noncompliers; no provisions are made for households facing financial or physical difficulties (e.g., elderly, handicapped); subsidies are being shifted from hardware to promotion, instead of being eradicated; and the lowest cost toilets may have lower durability and be harder to clean with resulting gender implications. The full reference for this review is Sijbesma, C. (2008). Sanitation and Hygiene in South Asia: Progress and Challenges. In Use by All: A Collection of Case Studies from Sanitation and Hygiene Promotion Practitioners in South Asia. The Netherlands: IRC. The CLTS approach is generally applicable in rural areas; applications in peri-urban areas may prove to be more challenging, even though some analysts have discussed the success of an urban CLTS activity in Kalyani Municipality, India, and DFID has discussed it in a newsletter, which may be found at http://www.dfid.gov.uk/Media-Room/Case-Studies/2009/The-first-open-defecation-free-municipality-in-India A 2007 evaluation of the WaterAid CLTS program in Nigeria reported that CLTS worked better in communities with fewer than 3,000 people and was less effective in “more urbanized communities partly due to the limited sense of community and the large number of tenant occupied houses.” Given the rewards that are offered for achieving ODF status, communities may find it easier to achieve ODF status than to maintain it over time.
Baseline Timeframe	A baseline may be collected as soon as USG-funded assistance is initiated. The first year for which data is collected for this indicator will vary for each operating unit.
Disaggregate(s)	None

3.1.7 – Family Planning and Reproductive Health

Indicator:	3.1.7-38 MCPR: Modern method contraceptive prevalence rate
Definition	Percent of reproductive age women in union who are currently using a modern method of contraception Numerator: Number of women in union of reproductive age currently using a modern method of contraception Denominator: total number of women of reproductive age in union
Linkage to Long-Term Outcome or Impact	MCPR is a direct measure of the desired outcome of FP/RH programs. It is directly linked to reductions in unintended pregnancy and is a measure of the functioning of the Health System. When disaggregated by wealth quintile, the measure reflects the capacity of the health system to reach all clients in need of health services.
Indicator Type	Outcome
Unit of Measure	Percentage.
Use of Indicator	At the global level data are aggregated, and a rolling average is computed annually to report to Congress and to monitor overall progress in achieving USAID FP/RH program goals. At the country level, data (which are typically available every 5 years) is used for assessment of longer-term program impact, for assessing regional and rural-urban differences, for reviewing the reach of various program components and for developing new strategies and program directions.
Data Source and Reporting Frequency	Data are collected through national level surveys, typically DHS or CDC surveys typically every 5 years
Known Data Limitations	Validity – High Integrity – High Precision – high Reliability – High Timeliness – Data are available annually as global averages to provide an overall trend in the impact of FP/RH programming. At the country level data are available at approximately 5-year intervals for review of progress in achieving current strategies and developing new strategies
Baseline Timeframe	Global baseline: 2008 Country baseline: varies by country, generally most recent previous DHS
Disaggregate(s)	Wealth Quintile (lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm; Numerator, Denominator

Indicator:	3.1.7.1-1 Couple Years Protection in USG supported programs
Definition	The estimated protection provided by family planning methods during a one-year period, based upon the volume of all contraceptive methods provided to clients during that period.
Linkage to Long-Term Outcome or Impact	This indicator measures the amount of contraceptive coverage provided to a given population in a given year, which is related to contraceptive prevalence and reduction in unintended pregnancies. This indicator is an annually-available proxy for MCPR.
Indicator Type	Output
Unit of Measure	Number, specific to a particular year. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYPs for each method are then summed over all methods to obtain a total CYP figure. See USAID conversion factors at: http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html N.B. Goals for CYP may be appropriate at the level of the service delivery site or higher (e.g., district or national program level) for the purposes of planning or budgeting. CYP targets should not be set for individual service providers.
Use of Indicator	The information generated by this indicator can be used for program planning and measurement of trends, budget projections for estimation of costs of needed contraceptives by Missions, and USAIDW
Data Source and Reporting Frequency	Data will be collected from USAID-supported projects, and aggregated annually
Known Data Limitations	Validity – high Integrity –high Precision – high Reliability –high Timeliness – Available on regular basis from USAID-assisted projects
Baseline Timeframe	Varies by country, and is set when the program or project is developed.
Disaggregate(s)	None

Indicator	3.1.7.1-2 Percent of USG-assisted service delivery points (SDP) that experience a stock out at any time during the reporting period of a contraceptive method that the SDS is expected to provide
Definition	A stock out is the absence, regardless of duration, at a SDS of a contraceptive product (e.g. oral contraceptive pill or injectable) or related supplies (e.g. for insertion of IUDs or implants, or male and female sterilizations) that prevents the SDS from offering that method. USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance. Service Delivery Points: Clinics, hospitals, facilities (government, private or NGO/FBO) pharmacies, and/or social marketing sales points. Does not include community health workers (CHWs). Whether a SDP is expected to offer a particular contraceptive method may be determined from standard treatment guidelines or other national policy/program documents. Both the numerator and denominator should be reported to allow aggregation across countries. The numerator is number of SDPs that experienced a stock out of a contraceptive method any time during the year, regardless of duration or number of products out of stock. If a SDP is stocked out of different methods at the same or different times in the reporting period, this should be reported as single SDP that experienced a stockout during the year. If a SDP is recorded as stocked out of a method multiple times in the reporting period, this should be reported as one SPP that experienced stock outs during the year. The denominator is number of monitored SDPs that are expected to provide a contraceptive method.
Linkage to Long-Term Outcome or Impact	The availability of contraceptive products and related supplies is a critical determinant of the success of any family planning program. This indicator measures the ability of a supply system to maintain a constant supply of products and supplies to the SDP level, where clients seek to obtain their methods. N.B.: Given the critical importance of supply availability to the success of any USG-assisted FP program, this indicator applies where any kind of USG-funded FP assistance is provided, regardless of whether it includes direct support for contraceptive procurement or supply chain strengthening.
Indicator Type	Output
Unit of Measure	Percentage, specific to the year.
Use of Indicator	This indicator may be used by in-country program managers and

	stakeholders as a “high level” measure of how well a supply system is working and direct attention to whether further analysis is needed to guide program investments for supply chain strengthening. Where USG FP assistance is not directed at contraceptive procurement or supply chain strengthening, this indicator can serve to flag where lack of supplies to clients may constrain the success of other program investments and where assistance for supply availability may be warranted. This indicator can be used by USAID/W technical staff to support in-country managers in allocating resources and program planning. This measure, in the aggregate, can also inform stakeholders (e.g., Congress) on how well programs that are supported by USAID are progressing towards reliable availability of a range of family planning methods for clients.
Data Source and Reporting Frequency	The recommended “gold standard” methods for collecting data for this indicator are through the routine reporting by SDPs, on a monthly or quarterly basis, through a logistics management information system (LMIS) or through health-based methods that are currently being deployed where a LMIS is weak. Alternative methods are available, and in use, that can, through direct observation, provide point-in-time annual snapshots of availability at a sample of SDPs. These facility-based surveys include the End-Use-Verification tool (EUV), Logistics Indicator Assessment Tool (LIAT), and national physical inventories. Supportive supervision checklists can also be used to check for stock outs at a sample of SDPs. Missions are advised to consult with PRH (see POC below) before adopting any of these alternative methods to gather data for this indicator.
Known Data Limitations	As defined and reported, the “granularity” of this indicator has certain limitations. It will not capture recurring stock outs of a particular method across time within the reporting period. Nor will it capture stock out durations. If anything, the indicator is likely to be an underestimate of supply shortcomings. Regardless, it will be indicative of when there are supply-related issues of likely program concern. Data from routine SDP reporting will be more comprehensive, in terms of frequency of reporting throughout the year and national coverage, than data collected by the “point-in-time” sampling methods listed above. Sample design will determine how representative is the data that is collected by these methods. For the purposes of Foreign Assistance reporting, the validity, integrity, precision, reliability, and timeliness of data collected by any of the methods listed above can be addressed through known measures.
Baseline Timeframe	Varies by country, and is set when the program or project is developed..
Disaggregate(s)	No disaggregation needs to be reported to HQ in the PPR. It may be useful at the country level to collect and analyze data disaggregated by contraceptive method, as follows: Male condom, female condom, oral combination pill, oral progestin only pill, emergency contraceptive pill, injectable, implant, intrauterine device, male sterilization, female

	sterilization, standard days method, or by rural/urban or sub-national area(s); Numerator, Denominator
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Indicator:	3.1.7.1-3 Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services
Definition:	Numerator: Number of USG-assisted service delivery sites providing FP information and/or services. Denominator: Number of SDPs planned to receive USG assistance over life of project. USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance. Service Delivery Points: Clinics, hospitals, facilities (government, private or NGO/FBO) pharmacies, and/or social marketing sales points. <u>Does not include community health workers (CHWs).</u> FP counseling: FP information and/or FP counseling provided in the context of a visit with a FP service provider. FP Services: Provision of FP methods and or FP referrals.
Linkage to Long-Term Outcome or Impact	Increased FP use is related to its physical availability through numerous sites offering FP counseling and/or services, especially if the counseling and/or services are offered in a quality, client-friendly, convenient and affordable manner. An increased contraceptive prevalence rate (CPR) will reduce the unmet need for FP, number of unintended pregnancies, number of abortions, and neonatal, infant, child and maternal mortality and morbidity. Initially, the percent of USG-assisted FP SDPs should approach and reach 100%. However, overtime these FP SDPs should receive less USG assistance, ultimately graduating from it, as the host government, local NGOs/FBOs, private for-profit facilities, and social marketing sales points assume increasing and complete ownership and responsibility.
Indicator Type	Output
Unit of Measure	Percentage, cumulative over time. To aggregate the data, each country would report its numerator and denominator in order for the global percentage to be computed.
Use of Indicator	At the country level, data (typically available annually) is used for assessment of longer-term program output and impact and for developing new strategies and program directions and interventions.
Data Source and Reporting Frequency	Country level denominators are initially set when country level programs/projects are designed and typically held constant over the life of the project; although refinement as implementation progresses is possible. Country level numerators are reported annually by implementing partners in project/program reporting documents to the USG COTR/AOTR. Both denominators and numerators should be reported annually for aggregation and global computation.
Known Data Limitations	Validity – high Integrity – high Precision – high Reliability – high Timeliness – high
Baseline Timeframe	Varies by country; set when program or projects are designed.
Disaggregate(s)	Numerator, Denominator
Indicator:	3.1.7.1-4 Number of additional USG-assisted community health workers (CHWs) providing family planning (FP) information and/or services

	during the year
Definition	USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance. Community Health Workers (CHW): Any type of CHW as defined by country programs. FP Information: FP information and/or FP counseling provided by a CHW FP Services: FP referrals and/or methods provided by a CHW.
Linkage to Long-Term Outcome or Impact	Increased FP use is related to its physical availability through numerous sites, including door-to-door offering of FP information and/or services, especially if the information and/or services are offered in a quality, client-friendly, convenient and affordable manner. Increased family planning use reduces the unmet need for FP, number of unintended pregnancies, number of abortions, and neonatal, infant, child and maternal mortality and morbidity. Over time, these CHWs may receive less USG assistance, ultimately graduating from it, as the host government and local NGOs/FBOs assume increasing and complete ownership and responsibility.
Indicator Type	Output
Unit of Measure	Number of USG-assisted should represent only new, additional CHWs
Use of Indicator	At the country level, data (typically available annually) is used for assessment of progress towards longer-term program output and impact and for developing new strategies and program directions and interventions.
Data Source and Reporting Frequency	Country target numbers are initially set when country programs/projects are designed and typically held constant over the life of the project; although refinement as implementation progresses is possible. Country numbers are reported annually by implementing partners in project/program reporting documents submitted to USG COTR/AOTRs.
Known Data Limitations	Validity – high Integrity – high Precision – high Reliability – high Timeliness – high
Baseline Timeframe	Varies by country, and is set when the program or project is developed.
Disaggregate(s)	None

Indicator	3.1.7.2-1 Percent of audience who recall hearing or seeing a specific USG-supported FP/RH message
Definition	“Audience” is defined as the target population for the particular FP/RH message (e.g. women of reproductive age). “Recall” may include spontaneous mention and/or aided recall. “Specific USG-supported FP/RH message” refers to a USG-supported communication with some identifiable aspect (e.g., logo, character, etc) that the respondent could not name unless s/he had been exposed to the communication. This indicator is calculated as: Numerator: # of audience members to recall a specific (USG-supported) FP/RH message Denominator: Total # of audience members x100
Linkage to Long-Term Outcome or Impact	“Reaching” the audience is an important first step to increasing levels of knowledge of the FP/RH products, practices, or services in question.
Indicator Type	Output (process indicator)
Unit of Measure	Percent, specific to the year
Use of Indicator	This indicator is important in establishing exposure to FP/RH campaign(s). It could also be used as a building block for an indicator of the “dose-response effect” of increasing the number of exposures to the message[s].
Data Source and Reporting Frequency	- National, regional, or local sample surveys with members (preferably a representative sample) of the intended audience. - Annual Reporting
Known Data Limitations	This indicator on reach does not in itself indicate if the intended population learned anything from this exposure, or if they approved/disapproved of its content.
Baseline Timeframe	Varies by country, and is set when the program or project is developed.
Disaggregate(s)	Numerator, Denominator

3.1.8 - Water Supply and Sanitation

Indicator	3.1.8-31 Percent of the population using an improved drinking water source
Definition	Numerator: Number of persons within households in a population representative sample where head of household or designated adult answers the question “What is the main source of drinking water for members of your household?” with one of the following responses: water piped into dwelling, piped into yard/plot, public tap, protected well in dwelling, protected well in yard/plot, protected public well, tubewell/borehole, protected spring, or rainwater harvesting Denominator: Persons in population representative sample. Improved drinking water sources, according to the Joint Monitoring Programme (JMP), are ones that by nature of their construction or through active intervention are protected from outside contamination, in particular from contamination with fecal matter. These sources include: piped water into dwelling, plot, or yard; public tap/standpipe; tube well/borehole; protected dug well; protected spring; or rainwater collection. All other sources are considered to be “unimproved.” Unimproved drinking water sources, according to the JMP, are: unprotected dug well, unprotected spring, cart with small tank/drum, tanker truck, surface water (river, dam, lake, pond, stream, canal, irrigation channel), and bottled water. According to the JMP, “Bottled water is considered to be improved only when the household uses water from an improved source for cooking and personal hygiene. Where this information is not available, bottled water is classified on a case-by-case basis.” In some countries, bottled water is the best quality water available. This definition will have to be modified if the JMP definitions change. The wording and definition of this indicator follow international guidelines in order to present data that may be used in discussions with the donor community.
Linkage to Long-Term Outcome or Impact	Use of an improved drinking water source as defined is strongly linked to decreases in the incidence of waterborne disease especially among children under five. Diarrhea remains the second leading cause of child deaths worldwide.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Useful for program management and funding allocations and tracking MDGs
Data Source and Reporting Frequency	The WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation (http://www.wssinfo.org/data-estimates/introduction). For each country, JMP plots survey (often DHS or MICS survey results) and census data on a timescale from 1980 to the present. A linear trend line, based on the least-squares method, is drawn through these data points to provide estimates (wherever possible) for 1990, 1995, 2000, 2005, 2008,

	and beyond (at yet undetermined intervals). The total estimates are population weighted averages of the urban and rural numbers.
Known Data Limitations	The actual quality of source water is not measured directly and instead only assumed and thus may vary based on how well a specific source is protected. This limitation, however, is minor compared to its limitations in describing other important aspects of a drinking water source that determine the quantity of water that persons are likely to consume, which is an equally important determinant of the level of health and non-health benefits from particular drinking water sources. Specifically, this definition ignores the ease of access to the source, the sources reliability and its affordability. Ease of access (typically measured in the time taken to fetch water from a source) is a strong determinant of the amount of water that persons will consume. The time to fetch water can vary considerably based on the distance from a person's dwelling to the source and the amount of time spent waiting to draw water. The reliability of supply from some improved sources also may vary and limit either the quantity or regularity of its use. For example, a piped water connection may be a household's primary source of drinking water but water from this source may not be available daily or throughout the day, requiring the household to obtain drinking water from an alternative unimproved source at certain times. The reliability of primary water sources, such as protected wells or rainwater harvesting, may also suffer seasonal variations that force households to rely on alternative unimproved sources during certain seasons. The affordability of improved water sources varies significantly among urban dwellers that typically must pay for use of improved drinking water sources, e.g., from public taps. This indicator reflects sanitation coverage in the population, regardless of what funding source was used to increase coverage. It is not limited to USG foreign assistance.
Baseline Timeframe	The latest JMP estimate prior to project initiation.
Disaggregate(s)	Residence (urban and rural). Breakdown to be provided by contractor(s) implementing USG funded intervention; Numerator, Denominator

Indicator	3.1.8-32 Percent of population using an improved sanitation facility
Definition	Numerator: Number of persons within households in a population representative sample where head of household or designated adult answers the question “What kind of toilet facility do members of your household usually use?” with one of the following: flush or pour/flush facilities connected to a piped sewer system, septic system, or pit latrine; pit latrines with a slab; composting toilets; and ventilated improved pit latrines. Denominator: All persons in population representative sample An improved sanitation facility, defined according to the Joint Monitoring Programme (JMP), is one that hygienically separates human excreta from human contact and includes: flush or pour/flush facility connected to a piped sewer system; a septic system or a pit latrine; pit latrines with a slab; composting toilets; or ventilated improved pit latrines. Any other sanitation facilities are considered “unimproved.” Unimproved sanitation includes: flush or pour/flush toilets without a sewer connection; pit latrines without slab/open pit; bucket latrines; or hanging toilets/latrines. Households that use a facility shared with other households are also not counted as using an improved sanitation facility. The wording and definition of this indicator follows international guidelines in order to facilitate discussion about sanitation coverage issues with the donor community.
Linkage to Long-Term Outcome or Impact	Use of an improved sanitation facility by households is strongly linked to decreases in the incidence of waterborne disease among household members, especially among children under age five. Diarrhea remains the second leading cause of child deaths worldwide.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Useful in tracking the contribution of USG-funded activities to the Millennium Development Goals (MDGs)
Data Source and Reporting Frequency	The WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation (http://www.wssinfo.org/data-estimates/introduction). For each country, JMP plots survey (often Demographic Health Surveys (DHS) or Multiple Indicator Cluster Surveys (MICS) results) and census data on a timescale from 1980 to the present. A linear trend line, based on the least-squares method, is drawn through these data points to provide estimates (wherever possible) for 1990, 1995, 2000, 2005, 2008, and beyond (at yet undetermined intervals). The total estimates are population weighted averages of the urban and rural numbers.
Known Data Limitations	Not all household members may regularly use the noted improved sanitation facility. In particular, in many cultures young children are often left to defecate in the open and create health risks for all household members including themselves. The above question asked to measure this

	indicator does not capture such detrimental, uneven sanitation behavior within a household. If the JMP changes the definition of improved sanitation facilities to include certain types of shared sanitation facilities, the calculation of the indicator proposed here would have to be modified accordingly. This indicator reflects sanitation coverage in the population, regardless of what funding source was used to increase coverage. It is not circumscribed to USG foreign assistance.
Baseline Timeframe	The latest JMP estimate prior to project initiation.
Disaggregate(s)	Residence (urban and rural) and wealth quintile lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or DHS; Numerator, Denominator

Indicator	3.1.8-33 Percentage of children under age five who had diarrhea in the prior two weeks
Definition	Numerator: Number of children under five experiencing an episode of diarrhea (as defined by a survey respondent, usually the child's mother or other primary caregiver) at any time during the two weeks preceding data collection from a population representative sample. Denominator: Number of children under five years of age. A period prevalence measure of the percent of children under age five in a particular target population that have experienced an episode of diarrhea in the two weeks before data was collected.
Linkage to Long-Term Outcome or Impact	This indicator is population based and will help determine the extent to which 3.1.8 program area investments are leading to a reduction in diarrheal morbidity, typically one of the most important contributors to overall childhood morbidity and mortality in developing countries.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Useful for program management and funding allocations.
Data Source and Reporting Frequency	Demographic Health Survey (DHS) (http://www.measuredhs.com/countries/), Round 4 of Multiple Indicator Cluster Surveys (MICS) conducted by UNICEF (http://childinfo.org/mics4.html , tab Surveys), and third party population based surveys. Reporting frequencies will vary between countries based on the availability of such surveys.
Known Data Limitations	As this measure relies on self-reporting by a child's caregiver, the definition of "diarrhea" as interpreted by these informants may not be consistent. Because diarrhea prevalence often varies seasonally, survey results taken at different times of year will be difficult to compare. Diarrheal prevalence can vary considerably between years based on varying climatic or other environmental, economic, or security conditions. As such, tracking progress via this outcome indicator will be difficult without multiple years of data and considering these important confounding factors.
Baseline Timeframe	A representative survey conducted in the last 1-3 years prior to project initiation.
Disaggregate(s)	By sex and residence (urban and rural) and access to improved water sources and improved sanitation. Breakdown to be provided by contractor(s) implementing USG funded intervention; Numerator, Denominator

Indicator	3.1.8.1-1 Percent of households using an improved drinking water source
Definition	Numerator: Number of household representatives in the USG-assistance project “zone of influence” (i.e., the sub-national geographic region targeted by USG assistance) answering the question “What is the main source of drinking water for members of your household?” with one of the following responses: water piped into dwelling, piped into yard/plot, public tap, protected well in dwelling, protected well in yard/plot, protected public well, tubewell/ borehole, protected spring, or rainwater harvesting. Denominator: All households in the sample randomly selected from within the USG-funded project zone of influence. Improved drinking water sources are defined according to the Joint Monitoring Programme (JMP) definition are sources that, by nature of their construction or through an active intervention, are protected from outside contamination, in particular from contamination with fecal matter. These sources include: piped water into dwelling, plot, or yard; public tap/standpipe; tube well/borehole; protected dug well; protected spring; or rainwater collection. All other sources are considered to be “unimproved.” Unimproved drinking water source are: unprotected dug well, unprotected spring, cart with small tank/drum, tanker truck, surface water (river, dam, lake, pond, stream, canal, irrigation channel), and bottled water. Bottled water is considered to be improved only when the household uses water from an improved source for cooking and personal hygiene. Where this information is not available, bottled water is classified on a case-by-case basis. In some countries, bottled water is the best quality water available. This definition will have to be modified if the JMP definitions change. A household is defined as a person or group of persons that usually live and eat together, using and contributing to a common source of income.
Linkage to Long-Term Outcome or Impact	Use of an improved drinking water source as defined is strongly linked to decreases in the incidence of waterborne disease, especially among children under age five. Diarrhea remains the second leading cause of child deaths worldwide.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Useful for program management and funding allocations.
Data Source and Reporting Frequency	Household surveys conducted annually by the USAID contractors or grantees implementing activities in the zone of influence or a third party evaluator using a representative sample of households in that zone of influence. If a year is skipped or the data come in after a given PPR reporting period, available data will appear in the following PPR.
Known Data Limitations	The actual quality of source water is not tested directly and instead only assumed and thus may vary based on how well a specific source is

	protected. This limitation, however, is minor compared to its limitations in describing other important aspects of a drinking water source that determine the quantity of water that persons are likely to consume, an equally important determinant of the level of health and non-health benefits from particular drinking water sources. Specifically, this definition ignores the ease of access to the source, the sources reliability and its affordability. Ease of access (typically measured in the time taken to fetch water from a source) is a strong determinant of the amount of water that persons will consume. The time to fetch water can vary considerably based on the distance from a person's dwelling to the source and the amount of time spent waiting to draw water. The reliability of supply from some improved sources may vary and limit either the quantity or regularity of its use. For example, a piped water connection may be a household's primary source of drinking water but water from this source may not be available daily or throughout the day, requiring the household to obtain drinking water from an alternative unimproved source at certain times. The reliability of primary water sources, such as protected wells or rainwater harvesting, may also suffer seasonal variations that force households to rely on alternative unimproved sources during certain seasons. The affordability of improved water sources varies most significantly among urban dwellers who typically must pay for use of improved drinking water sources, e.g., from public taps. Depending on monitoring and evaluation budget availability, the high cost of conducting representative household surveys especially in large zones of influence may limit the ability of USAID to track this indicator with a high degree of accuracy on an annual basis.
Baseline Timeframe	A baseline must be established before the start of activity implementation through an initial household survey conducted by the USAID contractors or grantees implementing activities or a third party evaluator using a representative sample of households in the zone of influence.
Disaggregate(s)	Residence (urban and rural). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or DHS; Numerator, Denominator

Indicator	3.1.8.1-2 Number of people gaining access to an improved drinking water source
Definition	Persons are counted as “gaining access” to an improved drinking water source if two conditions are met. One, if the source is either newly established or rehabilitated from a non-functional state within the reporting fiscal year as a result of USG assistance, <i>and</i> these persons did not previously have similar “access” to an improved drinking water source prior to the establishment or rehabilitation of the USG-supported improved source. And two, if the “time to collect” water from this source, i.e. the time it takes going to the water source from their dwelling, waiting, collecting water and returning home, does not exceed 30 minutes. Given this definition, the number of people considered to have “gained access” to an improved source will be limited by the physical distance to the source from beneficiaries’ dwellings, the amount of time typically spent queuing at the source, and the production capacity of the source. Estimates of the number of persons gaining access to a particular improved source are further limited by the minimum amount of water that this source will plausibly produce in a typical year. Specifically, the improved source must be able to consistently produce 20 liters per day for each person counted as “gaining access.” This amount is considered the daily minimum required to effectively meet a person’s drinking, sanitation, and hygiene needs. “Improved” drinking water sources are further defined by the quality of the water they produce, and are protected from fecal contamination by the nature of their construction or through an intervention to protect from outside contamination. Such sources include: piped water into dwelling, plot, or yard; public tap/standpipe; tube well/borehole; protected dug well; protected spring; or rainwater collection. Unprotected dug well, unprotected spring, cart with small tank/drum, tanker truck, surface water (river, dam, lake, pond, stream, canal, irrigation channel), and bottled water are not considered improved sources. Bottled water is only considered to be improved when the household uses water from an improved source for cooking and personal hygiene.
Linkage to Long-Term Outcome or Impact	Use of an “improved” drinking water source, as defined, is strongly linked to decreases in the incidence of waterborne disease especially among children under age five. Diarrhea remains the second leading cause of child deaths worldwide. While not guaranteeing “use” of the improved drinking water source, this indicator measures progress in making high quality drinking water available/ “accessible” in a manner that typically leads to use of the improved source.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Useful for program management and funding allocations
Data Source and Reporting Frequency	Upon completion of construction or rehabilitation of an improved water source, the USAID contractors or grantees implementing activities or a

	third party evaluator makes observations on and/or interviews initial users of the water source regarding the “time to collect” in relationship to the distance to their dwelling, and water source production volume measurements. This information is used to estimate the maximum distance from the source where “time to collect” among potential users would likely be 30 minutes or under. The number of persons living within that radius of the source currently not using an improved drinking water supply source according the baseline is the initial estimate of those “gaining access” to the source. This number might be further reduced, however, depending upon the measured production volume of the source in comparison to the 20 liters/capita/day minimum standard. These estimates would then be summarized and reported on a quarterly to annual basis depending on the specifications in the contract or grant agreement.
Known Data Limitations	The actual quality of source water is not measured directly and instead only assumed and thus may vary based on how well a specific source is protected. Providing “access” does not necessarily guarantee beneficiary “use” of an improved drinking water source and thus potential health benefits are not certain to be realized from simply providing “access.” Although, the chosen definition of “access” <i>does</i> attempt to define standard ease of use/accessibility and minimum volume of water to meet potential user needs, this definition <i>does not</i> capture the water source’s reliability or its affordability--two other important factors that influence the likelihood that those defined as having “access” will actually use the source. This indicator can be difficult and time consuming to measure accurately and requires robust data quality assurance on the part of USAID.
Baseline Timeframe	A baseline must be established among potential beneficiaries before the start of activity implementation to measure current “time to collect” and type of existing “main drinking water source” through an initial household survey, using a representative sample of households, conducted by the USAID contractors or grantees implementing activities or a third party assessor.
Disaggregate(s)	Residence (urban and rural). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or DHS.

Indicator	3.1.8.1-3 Number of people receiving improved service quality from existing improved drinking water sources
Definition	A person is counted for this indicator when: • They currently use as their main source an “improved drinking water source”, i.e., piped water into dwelling, plot, or yard; public tap/standpipe; tube well/borehole; protected dug well; protected spring; or rainwater collection; <i>but</i>, • The quality of “service” they receive from that source or an alternative improved drinking water source is further “improved” as a result of USG assistance in terms of its ease of access, reliability, and/or affordability. Specifically, “improved service quality” is defined as being achieved if: • The ease of access measure, time taken to fetch water from an improved source, is reduced to less than 30 minutes; • The reliability of supply improves such that the person’s main source is available regularly, i.e. there is no regular rationing of supply or regular seasonal failure of their improved source; and/or, • The affordability of their improved drinking water source improves such that the average price they pay for water is no higher than two times the average water tariff for piped water into the dwelling in their country (this particular measure recognizes the fact that many of the urban poor pay 2-10 times the price for public tap stand or water purchased from neighbors).
Linkage to Long-Term Outcome or Impact	Poor quality service (i.e., difficult to access, unreliable, or expensive) from improved drinking water sources discourage people from consuming the minimum amount of water required for drinking, sanitation and hygiene and thus contributes to elevated waterborne disease. Unreliable supplies can also force individuals to switch to unsafe sources during times of shortage. Finally, being forced to rely on expensive improved water sources creates adverse economic burdens on many of the poor; this diversion of household resources away from other important expenditures on food and other household staples also has implications for health.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Useful for program management and funding allocations
Data Source and Reporting Frequency	Program records of number of beneficiaries of water supply systems constructed/renovated in a 12-month period. This information will be collected by implementing agencies and will include information about accessibility, reliability and affordability. Accessibility will be established by counting the number of individuals living in households within a 10-minute walking radius from the water source; reliability will be established by determining the number of days within each quarter that the source was operational; and affordability will be established by the fees collected from users for different volumes of water sold. This information will be corroborated by an annual intercept survey conducted by USAID contractors at the point of water distribution twice a year, during the dry and the rainy season. An intercept survey is a short structured interview carried out by an enumerator at a desired location, which, in this case,

	would be the water distribution point.
Known Data Limitations	This indicator can be difficult and time-consuming to measure accurately and requires robust data quality assurance on the part of USAID.
Baseline Timeframe	A baseline survey on the existing quality of service available in the targeted zone of influence needs to be completed before the initiation of USG-funded interventions.
Disaggregate(s)	Residence (urban and rural). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or FSL.

Indicator	3.1.8.2-1 Percent of households using an improved sanitation facility
Definition	Numerator: Number of heads of households or designated adults in the USG-assistance project “zone of influence” (i.e., the sub-national geographic region targeted by USG assistance) that answer the question “What kind of toilet facility do members of your household usually use?” with one of the following: flush or pour/flush facilities connected to a piped sewer system, septic system, or pit latrine; pit latrines with a slab; composting toilets; and ventilated improved pit latrines.” Denominator: All households in the sample randomly selected in the project zone of influence. A household is defined as a person or group of persons that usually live and eat together, using and contributing to a common source of income. An improved sanitation facility is defined as one that hygienically separates human excreta from human contact and includes: a flush or pour/flush facility connected to a piped sewer system; a septic system or a pit latrine; pit latrines with a slab; composting toilets; or ventilated improved pit latrines. Unimproved sanitation includes: flush or pour/flush toilets without a sewer connection; pit latrines without slab/open pit; bucket latrines; or hanging toilets/latrines. Households that use a facility shared with other households are also not counted as using an “improved sanitation facility.”
Linkage to Long-Term Outcome or Impact	Use of an improved sanitation facility by households is strongly linked to decreases in the incidence of waterborne disease among household members, especially among those household members that are children under age five. Diarrhea remains the second leading cause of child deaths worldwide.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Useful in program management and funding allocation as it is connected with tracking intervention effectiveness and the contribution of USG-funded activities to the sanitation MDG.
Data Source and Reporting Frequency	Household surveys conducted on an annual basis by the USAID contractors or grantees implementing activities in the zone of influence or a third party evaluator using a representative sample of households in that zone of influence.
Known Data Limitations	The term “use” in the question asked to gauge access to sanitation facilities is employed to mean both existence and actual utilization of the facility. This is self-reported and it is not an objective measure of use, which would require observing the facility and determining if there are signs of usage (smell, flies, anal cleansing materials, etc.) Furthermore, not all household members may regularly use the noted improved sanitation facility. In particular, in many cultures, young children are often left to defecate in the open, which creates health risks for all household members including themselves. The question asked to measure this indicator does not capture such detrimental, uneven sanitation behavior within a household. If the Joint Monitoring Programme (JMP) changes the definition of

	improved sanitation facilities to include certain types of shared facilities, the calculation of the indicator proposed here would have to be modified accordingly. Depending on monitoring and evaluation budget availability, the high cost of conducting representative household surveys especially in large zones of influence may limit the ability of USAID to track this indicator on an annual basis.
Baseline Timeframe	A baseline must be established before the start of activity implementation through an initial household survey conducted by the USAID contractors or grantees implementing activities or a third party evaluator using a representative sample of households in the zone of influence.
Disaggregate(s)	Urban and rural and wealth quintile wealth quintile lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or DHS; Numerator, Denominator

Indicator	3.1.8.2-2 Number of people gaining access to an improved sanitation facility
Definition	An improved sanitation facility is defined as one that hygienically separates human excreta from human contact and includes: a flush or pour/flush facility connected to a piped sewer system; a septic system or a pit latrine; pit latrines with a slab; composting toilets; or ventilated improved pit latrines. Unimproved sanitation includes: flush or pour/flush toilets without a sewer connection; pit latrines without slab/open pit; bucket latrines; or hanging toilets/latrines. Members of households that use a facility shared with other households are not counted as using an “improved sanitation facility.” A household is defined as a person or group of persons that usually live and eat together. Persons are counted as “gaining access” to an improved sanitation facility, either newly established or rehabilitated from a non-functional or unimproved state, as a result of USG assistance if their household did not have similar “access”, i.e., an improved sanitation facility was not available for household use, prior to completion of an improved sanitation facility associated with USG assistance. This assistance may come in the form of hygiene promotion to generate demand. It may also come as programs to facilitate access to supplies and services needed to install improved facilities or improvements in the supply chain(s).
Linkage to Long-Term Outcome or Impact	Use of an improved sanitation facility by households is strongly linked to decreases in the incidence of waterborne disease among household members, especially among those under age five. Diarrhea remains the second leading cause of child deaths worldwide.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Useful in program management and funding allocation
Data Source and Reporting Frequency	Direct count of beneficiary households and estimates of the number of people living in those households by the USAID contractors or grantees implementing activities in the zone of influence or a third party evaluator and summarized on a quarterly or annual basis. This method would be most appropriate when the technical approach being pursued involves some direct household engagement by the USAID grantee or contractor, e.g., when a household is provided a subsidy for the construction of an improved sanitation facility.
Known Data Limitations	When using the survey method (method 1) to measure this indicator, it may be difficult to associate with certainty any reported sanitation facility improvements with USG assistance. For example, households might have improved their facilities regardless of any USG assistance. If the Joint Monitoring Programme changes the definition of improved

	sanitation facilities to include certain types of shared facilities, the calculation of the indicator proposed here would have to be modified accordingly.
Baseline Timeframe	If a sample survey is used to estimate the number of those “gaining access” (method 1), then a baseline must be established before the start of activity implementation through an initial household survey conducted by the USAID contractors or grantees implementing activities or a third party evaluator using a representative sample of households in the zone of influence.
Disaggregate(s)	Sex, residence (urban and rural). Breakdown to be provided by contractor(s) implementing USG funded intervention and/or DHS.

Indicator	3.1.8.2-3 Number of improved toilets provided in institutional settings
Definition	Institutional settings are defined as schools and health facilities. Schools in the context of this indicator are day schools for children 6 to 18 years of age who return home after school. Schools may be public or private. Health facilities may provide different levels of service, but it is anticipated that sanitation facilities will be installed in health facilities at the lower echelons of the service hierarchy. Health facilities may be public or private. A “toilet” is defined as an improved sanitation facility provided as a result of USG assistance that provides privacy and separates human excreta from human contact. Each toilet should have a squat hole. For latrine blocks with several squat holes, the “toilet” count is the number of squat holes in the block. Toilets that are repaired in order to meet set local government standards will also be counted. Toilets counted are only those that have hand washing facilities within or near the toilets. In school settings, there must be gender-specific toilets and host country standards regarding the ratio of students per squat hole must be met.
Linkage to Long-Term Outcome or Impact	Per WHO guidelines, “Schools with poor water, sanitation and hygiene conditions, and intense levels of person-to-person contact, are high-risk environments for children and staff, and exacerbate children's particular susceptibility to environmental health hazards.” Health facilities, like any other public space, must have sanitation facilities to reduce the possibility of spreading disease. Per WHO guidelines, “hospitals and health centers have special requirements for sanitation as they may have to deal with patients who are infected with diseases such as cholera, typhoid and hepatitis.”
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	For program management and to make funding allocation decisions.
Data Source and Reporting Frequency	Direct observations of all institutional setting sites targeted by USG assistance conducted on an annual basis by the USAID contractors or grantees implementing activities or a third party evaluator.
Known Data Limitations	For schools, the measurement of this indicator will not reflect a specific ratio of students per squat hole. For any institutional setting considered, the cleanliness of the sanitation facility will not be reflected either.
Baseline Timeframe	No baseline is needed for this output indicator.
Disaggregate(s)	By type of institution (school or health facility) and location (urban or rural)

Indicator	3.1.8.3-1 Number of new policies, laws, agreements, regulations, or investment agreements (public or private) implemented that promote access to improved water supply and sanitation
Definition	Policies, laws, agreements, and regulations include those developed with USG assistance and formed and formally endorsed by government, non-government, civil society and/or private sector stakeholders at the local, national, or international scale, with the intent to strengthen water supply and sanitation service delivery, including quality, access, and sustainability. Laws, regulations and policies are enacted by public sector institutions with responsibility for the water supply and sanitation sector. Utilities, either public or private, also establish policies or enter into agreements to promote improved water supply and sanitation service delivery. Investment agreements will include all public and private investments, both direct investment and the extension of credit to support improved service delivery. Implementation is demonstrated by existence of adequate institutional structure, capacity, and investment necessary to carry out changes.
Linkage to Long-Term Outcome or Impact	This indicator will contribute to the measurement of stakeholder commitment to improved drinking water and sanitation access and use, an important contributor to the reduction of water borne disease.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	To measure progress in improving the enabling environment for improving waste supply and sanitation access.
Data Source and Reporting Frequency	Direct count of new relevant policies, laws, agreements, regulations implemented by stakeholders targeted by USG assistance conducted on an annual basis by the USAID contractors or grantees implementing activities or a third party evaluator.
Known Data Limitations	It may be difficult to determine the precise existence and extent of “adequate” institutional structure, capacity, and investment necessary to carry out changes proposed in the new policies, laws, agreements, regulations, or investment agreements.
Baseline Timeframe	The baseline for this indicator will be zero. New developments will be counted.
Disaggregate(s)	Not applicable

Indicator	3.1.8.4-1 Public sector expenditures on drinking water and sanitation as a percentage of national budget
Definition	Public sector expenditures on drinking water and sanitation are defined as: on-budget spending on drinking water and sanitation capital expenditures and relevant recurrent costs—i.e. salaries, non-salaries, and recurrent subsidies to water and sanitation utilities. These should include central government, all local government spending on drinking water and sanitation, and all on-budget external funding expended on drinking water and sanitation. Numerator: Total public sector expenditures on drinking water and sanitation. Denominator: Total on-budget government expenditures.
Linkage to Long-Term Outcome or Impact	Increasing government expenditure on drinking water, sanitation and hygiene related programs and infrastructure is an indication that the government supports these efforts and such programs could be sustained. Over the long term, increased government investment in water and sanitation improvements would be expected to translate into health improvements given the importance of these improvements to reductions in diarrheal disease. In addition, by donors making more of their resources directly accessible or accountable to government planning (a USAID Forward principle), e.g., on-budget, it will be easier for governments to rationally prioritize investments, track expenditures, and monitor outcomes.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Measure government water and sanitation expenditures levels
Data Source and Reporting Frequency	Survey of government representatives conducted on an annual basis by the USAID contractors or grantees implementing activities or a third party evaluator using the survey methodology piloted by the UN-Water Global Annual Assessment of Sanitation and Drinking Water (GLAAS) Report (www.who.int/water_sanitation_health/glaas/en/) in 2009.
Known Data Limitations	None of this data will be easy to collect. Only a limited number of governments responded with such data, when the UN first attempted to gather it in 2009. It may be particularly difficult to collect data on non-central government expenditures, i.e., from the regional, state or municipal level.
Baseline Timeframe	
Disaggregate(s)	Not applicable

Indicator	3.1.8.5-1 Percent of a drinking water utility's supply that is non-revenue
Definition	Non-revenue water is water produced by a utility operator for which revenue is not collected. Non-revenue drinking water consists of: unbilled authorized consumption (unbilled metered and non-metered consumption), apparent losses (unauthorized consumption and metering inaccuracies), and real losses (leakages on transmission or distribution mains, leakages and overflows on utility storage tanks, and leakages on service connections). This indicator counts all types of non-revenue drinking water. Numerator: Total annual cubic meters of non-revenue water for a utility supported by USG assistance Denominator: Total annual cubic meters of water treated and distributed by the same utility supported by USG assistance
Linkage to Long-Term Outcome or Impact	Water utilities with high levels of non-revenue producing water (e.g., over 25%) indicate poorly maintained infrastructure and/or poorly organized billing and collection systems. Both situations threaten the sustainability of existing water supply provision and reduce the water utilities' ability to expand drinking water supply to households without current access—the key higher level drinking water supply outcome indicator.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Determine water supply efficiency in regards to leakages and effectiveness in monitoring nonpayment and illegal connections. It may help reduce consumers paying for inefficiencies of water utilities, loss of a costly resource, and unnecessary investments in water production.
Data Source and Reporting Frequency	Annual analysis of a water utility operator's or regulator's records of water production, revenue collection and other complementary data on flows in the utility's system conducted by the USAID contractors or grantees implementing activities in support of the utility or a third party evaluator.
Known Data Limitations	Poor metering of water systems and poor record keeping on bill collection may cause non-revenue water to be undercounted and/or the estimation of total cubic meters of water produced and distributed by a utility to be incorrect. Metering of water use at the level of production (wells, bulk water supply), at key points in the distribution network and for consumers is essential to estimate levels of non-revenue water, but does not always occur.
Baseline Timeframe	Baselines need to be established.
Disaggregate(s)	Numerator, Denominator

3.1.9 - Nutrition

Indicator	3.1.9-16 Prevalence of underweight children under five years of age
Definition	<i>Underweight children</i> is a weight-for-age measurement. Underweight is a reflection of acute and/or chronic undernutrition. This indicator measures the percent of children 0-59 months who are underweight, as defined by a weight for age Z score < -2. The numerator for this indicator is the total number of children 0-59 months surveyed with a weight for age Z score < -2. The denominator is the total number of children 0-59 months surveyed with weight for age Z score data.
Linkage to Long-Term Outcome or Impact	Reducing the prevalence of underweight children under five is the goal of the Feed the Future Initiative (FTF). The prevalence of underweight children is also an indicator to monitor the Millennium Development Goal (MDG) 1 "Halving the number of people who are hungry". Monitoring the prevalence of underweight children 0-59 months therefore allows the United States Agency for International Development (USAID) and its partners to show the contribution of FTF and Global Health Initiative (GHI) programs to the Millennium Development Goal.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both FTF and GHI.
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9-11 Prevalence of stunted children under five years of age
Definition	Stunting is a height-for-age measurement that is a reflection of chronic nutrition. This indicator measures the percent of children 0-59 months (i.e. under five years) who are stunted, as defined by a height for age Z score < -2. Children with a height for age Z score < -2 and ≥ -3 are classified as moderately stunted. Children with a height for age Z score < -3 are classified as severely stunted. This indicator will be a measurement of any stunting, i.e. both moderate and severe stunting combined. While stunting is difficult to measure in children 0-6 months and most stunting occurs in the 9-23 month range (1,000 days), this indicator data will still be reported for all children under 5 to align with the Demographic and Health Surveys (DHS) data and to capture the impact of interventions over time. The numerator for this indicator is the total number of children 0-59 months surveyed with a height for age Z score < -2. The denominator is the total number of children 0-59 months surveyed with height for age Z score data.
Linkage to Long-Term Outcome or Impact	Stunted, wasted, and underweight children under five years of age are the three major nutritional indicators. Stunting is an indicator of linear growth retardation, most often due to prolonged exposure to an inadequate diet and poor health. Reducing the prevalence of stunting among children, particularly 0-23 months, is important because linear growth deficits accrued early in life are associated with cognitive impairments, poor educational performance and decreased work productivity among adults. Better nutrition leads to increased cognitive and physical abilities, thus improving individual productivity in general, including improved agricultural productivity.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both Feed the Future (FTF) and the Global Health Initiative (GHI).
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9-12 Prevalence of wasted children under five years of age
Definition	This indicator measures the percent of children 0-59 months who are acutely malnourished, as defined by a weight for height Z score < -2. Although different levels of severity of wasting can be measured, this indicator measures the prevalence of all wasting, i.e. both moderate and severe wasting combined. The numerator for the indicator is the total number of children 0-59 months surveyed with a weight for height Z score < -2. The denominator is the total number of children 0-59 months surveyed with weight for height Z score data.
Linkage to Long-Term Outcome or Impact	Stunted, wasted, and underweight children under five years of age are the three major nutritional indicators. Wasting is an indicator of acute malnutrition. Children who are wasted are too thin for their height, and have a much greater risk of dying than children who are not wasted.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both Feed the Future (FTF) and the Global Health Initiative (GHI). Wasting is a measurement of acute malnutrition and is the best measurement for the current status and rapid changes. It is calculated with information already collected for stunting and underweight.
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9-13 Prevalence of underweight women
Definition	This indicator measures the percent of non-pregnant women (NPW) of reproductive age (15-49 years) who are underweight, as defined by a body mass index (BMI) < 18.5. To calculate an individual's BMI, weight and height data are needed: $BMI = \text{weight (in kg)} \div \text{height (in meters)}^2$. The numerator for this indicator is the number of NPW 15-49 years surveyed with a BMI < 18.5. The denominator for this indicator is the number of NPW 15-49 years surveyed with BMI data.
Linkage to Long-Term Outcome or Impact	This indicator provides information about the extent to which women's diets meet their caloric requirements. Adequate energy in the diet is necessary to support the continuing growth of adolescent girls and women's ability to provide optimal care for their children and participate fully in income generation activities. Undernutrition among women of reproductive age is associated with increased morbidity, poor food security, and can result in adverse birth outcomes in future pregnancies. Improvements in women's nutritional status are expected to improve women's work productivity, which may also have benefits for agricultural production, linking the two strategic objectives of Feed the Future (FTF).
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both FTF and the Global Health Initiative (GHI).
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.9-6 Prevalence of anemia among women of reproductive age
Definition	Anemia is measured by hemoglobin concentration in the blood and, for this indicator, is collected among women of reproductive age (15-49 years). Non pregnant women (NPW) with a hemoglobin concentration less than 12g/dl and Pregnant women (PW) with a hemoglobin concentration less than 11g/dl are classified as anemic. The numerator for this indicator is the total number of anemic women 15-49 years surveyed. The denominator is the total number of women 15-49 years surveyed with hemoglobin data.
Linkage to Long-Term Outcome or Impact	This indicator emphasizes the importance of women's micronutrient nutrition both pre-pregnancy and during pregnancy for the growth and development of the child in-utero and for a safe delivery and positive birth outcome. Maternal anemia during pregnancy is associated with increased risk of hemorrhage, sepsis, maternal mortality, perinatal mortality, and low birth weight. Maternal micronutrient nutrition (including adequate iron stores) is also necessary to support optimal maternal care for the child, including nutrient content of breast milk fed to the child, during infancy and early childhood. This Intermediate Result (IR) emphasizes use of nutrition services with the assumption that if people use the health and nutrition services, anemia in women of reproductive age will drop.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both FTF and the Global Health Initiative (GHI).
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?survey_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.9-14 Prevalence of anemia among children 6-59 months
Definition	Anemia is measured by hemoglobin concentration in the blood and, for this indicator, is collected among children 6-59 months. Children with a hemoglobin concentration less than 11g/dl are classified as anemic. The numerator for this indicator is the total number of anemic children 6-59 months surveyed. The denominator is the total number of children 6-59 months surveyed with hemoglobin data. <i>Note that a similar indicator exists to measure anemia as associated with malaria. Although it may be difficult to determine whether a child's anemia is being caused by malaria or nutritional factors, report results under this indicator when measuring as part of a nutrition-related intervention and report results when measuring as part of a malaria-related intervention.</i>
Linkage to Long-Term Outcome or Impact	This indicator highlights the importance of micronutrient nutrition (iron status, in particular) for child health and development. Child anemia is associated with adverse consequences for child growth and development, including increased morbidity and impaired cognitive development.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Reducing undernutrition by a measurement of underweight, stunting, child's anemia or maternal anemia is the overall goal of both FTF and the Global Health Initiative (GHI).
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9-1 Number of people trained in child health and nutrition through USG-supported programs
Definition	Number of people (health professionals, primary health care workers, community health workers, volunteers, non-health personnel) trained in child health care and child nutrition through United States Government (USG)-supported programs during the reporting year.
Linkage to Long-Term Outcome or Impact	Development of human capacity through training is a major component of USG-supported health area programs in this element. The larger goal of reducing under nutrition cannot be achieved without increased capacity in both traditional health and non-traditional platforms.
Indicator Type	Output
Unit of Measure	Number ** For this indicator, please simply count the training attendance numbers without distinguishing whether the same person received multiple trainings. In that case, that person would be counted several times, which is acceptable for this indicator. **
Use of Indicator	This indicator allows the tracking of the number of people being trained. It can be used both by missions and globally.
Data Source and Reporting Frequency	Implementing partners' records of training attendance; Annually reported
Known Data Limitations	If the same person received multiple trainings, s/he is counted several times, which is acceptable for this indicator because it counts all instances of people being trained. Any training indicator has the fundamental problem of only capturing the training provided. The quality of neither the training nor the outcome of the training (whether the trainees learned any skills or whether they will use the taught skills) are measured with these indicators. For this purpose training includes any length of formal training, pre- or in-service for health professionals, primary health care workers, community health workers, volunteers, and non-health personnel. (An example of Non health personnel who could be counted would be agricultural extension agents). The level of training and requirements for the completion of a given training will be varied across country settings .
Baseline Timeframe	The first year in which data were collected for this indicator varies for each operating unit.
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9-15 Number of children under five reached by USG-supported nutrition programs
Definition	Number of children under five years of age reached during the reporting year by United States Government (USG) programs with nutrition objectives, which could include behavior change communication activities, home or community gardens, micronutrient fortification or supplementation, anemia reduction packages, growth monitoring and promotion and management of acute malnutrition. Count each child once, even if reached by multiple nutrition-related interventions.
Linkage to Long-Term Outcome or Impact	Good coverage of nutrition programs is essential to prevent and treat malnutrition and improve child survival.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	This indicator allows the tracking of the number of people being trained. It can be used both by missions and globally.
Data Source and Reporting Frequency	Implementing partners' records of interventions. Annually reported
Known Data Limitations	If the same child is reached multiple times, s/he is counted several times, which is acceptable for this indicator because it counts all instances of children being reached.
Baseline Timeframe	The first year in which data were collected for this indicator varies for each operating unit.
Disaggregate(s)	Sex

3.1.9.1 – Individual Prevention Programs

Indicator	3.1.9.1-1 Prevalence of children 6-23 months receiving a minimum acceptable diet
Definition	This indicator measures the proportion of children 6-23 months of age who receive a minimum acceptable diet (MAD), apart from breast milk. The “minimum acceptable diet” indicator measures both the minimum feeding frequency and minimum dietary diversity, as appropriate for various age groups. If a child meets the minimum feeding frequency and minimum dietary diversity for their age group and breastfeeding status, then they are considered to receive a minimum acceptable diet. Tabulation of indicator results require that data on breastfeeding, dietary diversity, number of semi-solid/solid feeds and number of milk feeds be collected for children 6-23 months the day preceding the survey. The indicator is calculated from the following two fractions: • Breastfed children 6-23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day • Breastfed children 6-23 months of age • Non-breastfed children 6-23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day • Non-breastfed children 6-23 months of age Minimum dietary diversity for breastfed children 6-23 months is defined as four or more food groups out of the following 7 food groups (refer to the WHO IYCF operational guidance document cited at bottom): • Grains, roots and tubers • Legumes and nuts • Dairy products (milk, yogurt, cheese) • Flesh foods (meat, fish, poultry and liver/organ meats) • Eggs • Vitamin-A rich fruits and vegetables • Other fruits and vegetables Minimum meal frequency for breastfed children is defined as two or more feedings of solid, semi-solid, or soft food for children 6-8 months and three or more feedings of solid, semi-solid or soft food for children 9-23 months. Minimum dietary diversity for non-breastfed children is defined as four or more food groups out of the following six food groups: • Grains, roots and tubers • Legumes and nuts • Flesh foods (meat, fish, poultry and liver/organ meats) • Eggs • Vitamin-A rich fruits and vegetables • Other fruits and vegetables

	Minimum meal frequency for non breastfed children is defined as four or more feedings of solid, semi-solid, soft food, or milk feeds for children 6-23 months, with at least two of these feedings being milk feeds .
Linkage to Long-Term Outcome or Impact	Appropriate feeding of children 6-23 months is multidimensional. The minimum acceptable diet indicator combines standards of dietary diversity (a proxy for nutrient density) and feeding frequency (a proxy for energy density) by breastfeeding status; and thus provides a useful way to track progress at simultaneously improving the key quality and quantity dimensions of children's diets.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	This thus provides a useful way to track progress at simultaneously improving the key quality and quantity dimensions of children's diets which is useful to missions to understand changes for programming and globally to track trends
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Numerator, Denominator, Sex, Wealth Quintile (lowest, second, middle, fourth, and highest), URL: http://www.measuredhs.com/topics/wealth/methodology.cfm

Indicator	3.1.9.1-4 Prevalence of exclusive breastfeeding of children under six months of age
Definition	This indicator measures the percent of children 0-5 months of age who were exclusively breastfed during the day preceding the survey. Exclusive breastfeeding means that the infant received breast milk (including milk expressed or from a wet nurse) and may have received oral rehydration salts, vitamins, minerals and/or medicines, but did not receive any other food or liquid. The numerator for this indicator is the total number of children 0-5 months surveyed exclusively breastfed in the day preceding the survey. The denominator is the total number of children 0-5 months surveyed.
Linkage to Long-Term Outcome or Impact	Exclusive breastfeeding for 6 months provides children with significant health and nutrition benefits, including protection from gastrointestinal infections and reduced risk of mortality, due to infectious disease.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	This provides a way to track optimal feeding for children less than 6 months which is useful to missions to understand changes for programming and globally to track trends
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?survey_id=228&country_id=33&SurveyType=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Sex; Numerator, Denominator

Indicator	3.1.9.1-2 Women's Dietary Diversity: Mean number of food groups consumed by women of reproductive age
Definition	This validated indicator aims to measure the micronutrient adequacy of the diet and reports the mean number of food groups consumed in the previous day by women of reproductive age (15-49 years). To calculate this indicator, nine food groups are used: 1. Grains, roots and tubers; 2. Legumes and nuts; 3. Dairy products (milk, yogurt, cheese); 4. Organ meat; 5. Eggs; 6. Flesh foods and other misc. small animal protein; 7. Vitamin A dark green leafy vegetables; 8. Other vitamin A rich vegetables and fruits; 9. Other fruits and vegetables From the collected data, the following two results are calculated: 1) Number and percent of women of reproductive age consuming each food group; 2) Mean number of food groups consumed by women of reproductive age. The indicator is tabulated by averaging the number of food groups consumed (out of the nine food groups above) across all women of reproductive age surveyed with data on dietary diversity.
Primary Program Area (Program Element for IIP) Linkage	3.1.9—Nutrition
Primary Program Element (Program Sub-Element for IIP) Linkage	3.1.9.1 Individual Prevention Programs
Linkage to Long-Term Outcome or Impact	Women of reproductive age are at risk for multiple micronutrient deficiencies, which can jeopardize their health and ability to care for their children and participate in income generating activities. Maternal micronutrient deficiencies during lactation can directly impact child growth and development but the potential consequences of maternal micronutrient deficiencies are especially severe during pregnancy, when there is the greatest opportunity for nutrient deficiencies to cause long term, irreversible development consequences for the child in-utero. Dietary diversity (assessed here as the number of food groups consumed) is a key dimension of a high quality diet with adequate micronutrient content; and thus, important to ensuring the health and nutrition of both women and their children.
Indicator Type	Outcome
Unit of Measure	Number
Use of Indicator	Dietary diversity (assessed here as the number of food groups consumed) is a key dimension of a high quality diet with adequate micronutrient content; and thus, important to ensuring the health and nutrition of both women and their children. This is useful to missions to understand changes for programming and globally to track trends
Data Source and	When surveys are available. The timeframe in any given country will be

Reporting Frequency	different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?survey_id=228&country_id=33&SurveyType=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	Numerator, Denominator

Indicator	3.1.9.1-3 Prevalence of households with moderate or severe hunger
Definition	This indicator measures the percent of households experiencing moderate or severe hunger, as indicated by a score of 2 or more on the household hunger scale (HHS). To collect data for this indicator, respondents are asked about the frequency with which three events were experienced by household members in the last four weeks: • No food at all in the house; • Went to bed hungry; • Went all day and night without eating. For each question, the following responses are possible: never (value=0), rarely or sometimes (value=1), often (value=2). Values for the three questions are summed for each household, producing a HHS score ranging from 0 to 6. The numerator for this indicator is the total number of households surveyed with a score of 2 or more on the HHS. The denominator is the total number of households surveyed with HHS data.
Linkage to Long-Term Outcome or Impact	Measurement of household hunger provides a tool to monitor global progress of United States Government (USG) supported food security initiatives. A decrease in household hunger is also a reflection of improved household resilience. The indicator has been validated to be meaningful for cross-cultural use using data sets from seven diverse sites.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	Measurement of household hunger provides a tool to monitor global progress of USG supported food security initiatives. A decrease in household hunger is also a reflection of improved household resilience. This is useful to missions to understand changes for programming and globally to track trends.
Data Source and Reporting Frequency	When surveys are available. The timeframe in any given country will be different. The Demographic and Health Survey (DHS) is implemented every 5 years. Information on the frequency of DHS by country can be obtained at: http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=228&ctry_id=33&SrvyTp=country
Known Data Limitations	DHS surveys are not conducted annually in any specific country, so data may not be available at the optimal intervals for evaluation.
Baseline Timeframe	Missions will report on most recent DHS. This will vary by country. A compilation of nutrition specific indicators updated in 2010 can be found at http://pdf.usaid.gov/pdf_docs/PNADT413.pdf
Disaggregate(s)	By sex household type: female no male (FNM); male no female (MNF); male and female (M&F); Numerator, Denominator

3.1.9.2 – Population-Based Nutrition Service Delivery

Indicator	3.1.9.2-2 Number of health facilities with established capacity to manage acute under-nutrition
Definition	A health facility may include government health clinics, private clinics as well as clinics run by community-based organizations or local Non-Governmental Organizations (NGOs). Many health facilities are set up by International NGOs (INGOs), who may also provide staff training. As long as a local entity is actually running the facility, it can be counted here, even if a non-local entity was influential in setting up, funding, or training the staff. An “established capacity to manage acute under nutrition” indicates the organization has a program with established procedures, methods and appropriate materials (resources, trained staff, etc.) to address acute under nutrition. An example of this could be a facility that meets the criteria on the National Protocol in the Community Management of Acute Malnutrition (CMAM) program. This indicator is asking how many health facilities have this type of management capacity. NOTE: This indicator should include all currently capable health facilities, and not only those who achieved the capability during this fiscal year. The intention is to reflect the current coverage of capable health facilities during each given fiscal year
Linkage to Long-Term Outcome or Impact	A key objective of Feed the Future (FTF) is the “Improved nutritional status, especially of women and children.” Assistance to the poor via health facilities that treat under-nutrition is a key component to achieving this objective.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	This indicator allows the tracking of the number of health facilities that treat under-nutrition. It can be used both by missions and globally
Data Source and Reporting Frequency	Implementing partners records Annually reported
Known Data Limitations	This indicator is a count of the number of facilities and does disaggregate by urban and rural. Is not an indicator of how many people are able to access a facility and obtain treatment.
Baseline Timeframe	
Disaggregate(s)	Urban and rural

Indicator	3.1.9.2-3 Number of children under five who received Vitamin A from USG-supported programs
Definition	Number of children under five years of age who received Vitamin A from United States Government (USG)-supported programs in the last 6 months from the time this data is collected. In order to best affect Vitamin-A deficiency, children need two rounds of coverage in one year. In order to not double count children, please only report the number done in the last 6 months.
Linkage to Long-Term Outcome or Impact	Vitamin A supplementation reduces risk of under-five mortality by about one-fourth among the millions of children deficient in this micronutrient
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	USAID has a long and successful history of support to Vitamin A supplementation. This indicator allows the tracking of the number of children who receive vitamin A. It can be used both by missions and globally
Data Source and Reporting Frequency	Implementing partners records for the previous 6 months for USG supported projects. Annually reported
Known Data Limitations	Ideally children receive two doses within one year. Reporting on this indicator will know be done annually for the previous six months, so as not to duplicate children receiving the dose.
Baseline Timeframe	Dependent on country
Disaggregate(s)	Urban and rural

3.1.9.3 – Nutrition Enabling Environment and Capacity

Indicator	3.1.9.3-1 Percentage of national budget invested in nutrition service delivery
Definition	This indicator provides the amount of funding from the country's national budget directed towards nutrition. This figure will most likely be reflected in line items under the Ministry of Health (MOH) and/or the Ministry of Agriculture (MOA).
Linkage to Long-Term Outcome or Impact	To measure sustainable public sector investment in nutrition activities, we will measure the amount and percentage of national budget allocated to nutrition. Public investment in nutrition demonstrates the host government's commitment to improving the nutritional status of its citizens and is a core component of the Scaling Up Nutrition (SUN) movement.
Indicator Type	Outcome
Unit of Measure	Percent
Use of Indicator	This indicator allows for the tracking of changes in expenditure on nutrition. It can be used both by field missions and national programs.
Data Source and Reporting Frequency	Host government budget sheets. Annually
Known Data Limitations	This information may not be able to be collected in all countries. It may be difficult to collect this information. This indicator is being promoted at a global level and will be easier to collect over time.
Baseline Timeframe	
Disaggregate(s)	Numerator, Denominator

3.2 - Education

3.2.1 – Basic Education

Indicator	3.2.1-3 Number of administrators and officials successfully trained with USG support
Definition	Number of education officials (public or private) or administrators of education programs, funds or institutions receiving training in aspects of their current positions, including areas such as management and quality assurance for improving reading skills at the primary level (Goal 1), or supporting the re-integration of conflict-affected youth into the formal or nonformal education systems (Goal 3). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. Training should be at least two working days (16 hours) in duration. Numbers must be reported separately for Goal 1 and Goal 3. For each goal, the officials/administrators counted must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, officials/administrators may be counted under both goals if they are beneficiaries of programming contributing to both goals. When calculating the total numbers of officials/administrators trained, however, each official/administrator should be counted only once. Note that the total count for officials/administrators trained should include only officials/administrators exposed to training contributing to either goal 1 or 3. Under each goal, report direct and indirect beneficiaries separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	USG training supports capacity building for host country education administrators and officials and their institutions. Counting the number of trainees provides an overall sense of scope. However, because the depth and duration of USG supported interventions varies, this is a limited indicator, meant to help ‘tell the story’ by giving an overall sense of the number of administrators/officials affected by USAID-supported efforts.
Indicator Type	Output
Unit of Measure	Number of officials and administrators
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Program documents and records from implementing partners, USG, host-country counterparts. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of officials and administrators trained. The validity of data will vary by country, and is dependent on avoiding double-counting the same trainees. USAID will verify the validity of the lists and numbers of trainees prior to reporting results. Integrity. Reporting on trainees has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work

	with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of trainees rather than aggregated numbers, in particular when numbers seem at odds with targets. Reliability. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USG-supported projects keep careful records of officials trained, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines
Baseline Timeframe	Existing indicator, so Missions with existing programs have years' worth of data.
Disaggregate(s)	Sex; goal 1 and goal 3; direct and indirect.

Indicator	3.2.1-14 Number of learners enrolled in primary schools and/or equivalent non-school based settings with USG support
Definition	Number of learners formally enrolled in primary schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This number may include learners receiving educational radio and/or TV programming. Numbers must be reported separately for Goal 1 and Goal 3. For each goal, the learners counted must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, learners may be counted under both goals if they are beneficiaries of programming contributing to both goals. For instance, primary school students in a post-conflict country benefitting from USG programming to improve access and improve reading skills, should be counted under both goals 1 and 3. When calculating the total numbers of learners enrolled, however, each learner should be counted only once. Note that the total should include only learners exposed to programming contributing to either goal 1 or 3. Under each goal, report direct and indirect beneficiaries separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	Counting the number of learners provides an overall sense of scope. However, the depth and duration of USG-supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USG efforts often focus on the hardest to reach populations. This indicator is designed to help tell in counting the annual, overall number of direct beneficiaries of USG programming.
Indicator Type	Output
Unit of Measure	Learner
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	USAID and implementing partners provide the data, from project/program records of students/learners enrolled. Where interventions are national, Ministry statistics may provide overall numbers. Data collected annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of learners. Integrity. Reporting on numbers of learners has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. When numbers seem at odds with targets, USAID will request full lists of numbers of learners rather than aggregated numbers.

	Reliability. Partners have established, consistent systems for reporting results. Administrative data, from Ministries of Education, use the same processes year to year, but may have a high incidence of missing or inaccurate data. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of learners reached, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timeliness.
Baseline Timeframe	Existing indicator, so Missions with existing programs have years' worth of data. Baseline is year before start of implementation of strategy.
Disaggregate(s)	Sex; by goal 1 or goal 3; and by direct/indirect.

Indicator	3.2.1-15 Number of learners enrolled in secondary schools or equivalent non-school based settings with USG support
Definition	Number of learners formally enrolled in secondary schools or equivalent non-school based settings for the purpose of acquiring academic basic education skills or knowledge. This number may include learners receiving educational radio and/or TV programming. Under each indicator and strategy goal, both direct and indirect beneficiaries should be reported. Direct beneficiaries are reached with direct USAID assistance. Indirect beneficiaries include learners where an agreement about taking a USAID-funded and evaluated pilot, intervention, or program to scale exists between USAID and another donor(s), or where USAID provided only a portion of the funding for a given treatment in partnership with donor and country partners. For learners reached indirectly, Missions should take into account the change in school populations attributable to population growth or decline, and adjust numbers of learners accordingly.
Linkage to Long-Term Outcome or Impact	Counting the number of learners provides an overall sense of scope. However, the depth and duration of USAID-supported interventions varies. Also, it is easier to reach learners in urban areas, whereas USAID efforts often focus on the hardest to reach populations. Hence, this is a limited indicator, meant to help tell USAID's story by counting the annual, overall number of direct beneficiaries of USAID's programming.
Indicator Type	Output
Unit of Measure	Learner
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	USAID and implementing partners provide the data, from project/program records of students/learners enrolled. Where interventions are national, Ministry statistics may provide overall numbers. Data collected annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of learners. Integrity. Reporting on numbers of learners has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. When numbers seem at odds with targets, USAID will request full lists of numbers of learners rather than aggregated numbers. Reliability. Partners have established consistent systems for reporting results. Administrative data, from Ministries of Education, may use the same processes year to year, but have high incidence of missing or inaccurate data. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of learners reached, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timeliness.

Baseline Timeframe	Existing indicator, so Missions with existing programs have years' worth of data.
Disaggregate(s)	Sex; by goal 1 or goal 3; and by direct/indirect.

Indicator	3.2.1-18 Number of PTAs or similar ‘school’ governance structures supported
Definition	Involvement may be through PTAs, School Management Committees (SMC), or other similar governance bodies for an individual school (or equivalent non-school setting) supported by USAID (direct) or plausibly attributable to USAID interventions (indirect) to organize, meet regularly, participate more fully in education activities, contribute to monitoring school quality or school governance, or in any other way be more supportive of the school or non-school equivalent education setting. USAID support includes, but is not limited to, direct financial support (grants) and training in skills related to serving on a PTA, SMC, or equivalent governance body. Numbers must be reported separately for Goal 1 and Goal 3. For each goal, the numbers of entities that are involved in school support must include only those reached by programming contributing to each respective goal. Under each goal, report direct and indirect beneficiaries separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	Supporting school governance structures is an important way to promote capacity building at the grassroots, local level. Such structures promote opportunities for democracy in action as well as improved local ownership, accountability, stability, and education quality. This indicator provides an overall sense of scope. Because the depth of USAID supporting interventions varies, this is a limited indicator, meant to help ‘tell the story’ by giving an overall sense of the number of such structures affected by USAID-supported efforts.
Indicator Type	Output
Unit of Measure	Number of school governance structures
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data from project/program documents from implementing partners, USAID, host-country counterparts. Reported annually.
Known Data Limitations	Validity-Data represent the desired result. Integrity- Reporting on numbers of PTAs supported has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partners to reinforce the importance of integrity in reporting of results. Precision- When numbers seem at odds with targets, USAID will request full lists of school PTAs supported rather than aggregated numbers. Reliability-Partners have established, consistent systems for reporting results. USAID will verify the reliability of data prior to reporting results. Timeliness-Most USAID-supported projects keep careful records of PTAs

	supported, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timeliness.
Baseline Timeframe	Missions with existing programs have years' worth of data.
Disaggregate(s)	Goal 1 and Goal 3; direct/indirect beneficiaries.

Indicator	3.2.1-27 Proportion of students who, by the end of two grades of primary schooling, demonstrate that they can read and understand the meaning of grade level text
Definition	Proportion of learners who attain the specified threshold at the end of two grades of primary schooling, the beginning of the third year of primary schooling, or the equivalent levels of accelerated learning programs. Students and learners in formal and nonformal education programs should be included. Measures of the indicator will be determined in consultation with the country, and informed by national (or regional, if applicable) curriculum standards, and by international experience. <u>Illustrative</u> examples include country-specific benchmarks on national assessments that have satisfactory psychometric validity and reliability and limited corruption issues or levels of oral fluency based on acceptable oral assessments, e.g. demonstrating satisfactory levels of comprehension as measured by comprehension questions on grade 2 texts, or reading a country-determined number of words correct per minute. The language(s) of assessment will be determined by country policies. Any assessment system with adequate psychometric validity and reliability is acceptable, e.g. ASER, EGRA, and national assessments. A census of all the students and learners who received the treatment or intervention is not necessary. Rather, a statistical sample that is representative of that population is adequate. Those findings then may be extrapolated to the population. Numerator: Number of students and learners reading with sufficient understanding at the end of the first two grades of primary schooling (or nonformal equivalent). Denominator: Total number of students and learners at the end of the first two grades of primary schooling (or nonformal equivalent). Note: Proportions must be reported separately for direct and indirect beneficiaries. Under each indicator and strategy goal, both direct and indirect beneficiaries should be reported. Direct beneficiaries are reached with direct USAID assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is <i>plausible attribution</i> – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental. USAID Missions, in concert with Washington, will be responsible for creating measures and defining thresholds.
Linkage to Long-Term Outcome or Impact	This indicator is an outcome measure of the highest order for Goal 1 of the Education Strategy, which calls for improved reading skills for 100 million primary school children. Learning to read is the foundation for future learning in all subjects and at all levels of education. Improvements in basic literacy also have been shown to translate to higher national economic growth rates as well as to other population-level benefits.
Indicator Type	Outcome
Unit of Measure	Unit of measure is the student. Proportions of students/learners will be

	reported to indicate results against numbers of students/learners targeted. Proportions will range from 0 to 100%.
Use of Indicator	Simple, easily understood but flexible metrics, that countries can set for themselves for the language(s) of instruction that they use in the early grades, are essential tools for tracking student learning. The process of establishing information on early grade reading competencies and making instructional and management decisions based on the data is what is most important. Students and learners who do not have basic skills after completing two grades of primary schooling may repeat grades, drop out, or suffer academically in higher grades where they are expected to be able to use reading to learn, starting in the middle primary grades. Information will be used at the country level for the monitoring of reading improvement programs and to make corrections when necessary. It should also be noted that this indicator aligns with the quality indicators being adopted by other development organizations including FTI and DfID.
Data Source and Reporting Frequency	For students and learners in both formal and nonformal education programs, data will be generated through early grade reading assessments (most likely oral) carried out at the country level. Assessments will be done at baseline and endline, and possibly at midline as well, using comparable assessments given at the same grades or their equivalents (at the end of grade two, the beginning of grade 3, or at the equivalent level of accelerated learning programs). USAID will be responsible for ensuring that data are collected for outcomes, although these assessments may be carried out by or in partnership with host governments or other organizations, national or international. In many instances, because reading is not tested by existing government assessment systems or by national civil society organizations, these assessments will be designed and implemented by USAID and local or international implementing partners. Note that the sampling approach must generate data representative at the level of USG interventions. If, for instance, programs intervene in only two provinces, data representative of those two provinces must be collected. Nationally-representative data cannot be disaggregated by province unless the sampling frame was designed to do so, and is large enough for this type of disaggregation.
Known Data Limitations	Validity. This indicator is being used to represent overall reading performance at the early grades of schooling. This approach aligns with internationally adopted standards on early grade reading measurement. Integrity. Country programs will work in partnership with the host countries in both early grade assessment and programming. Substantial time for local level dialogue is built into the assessment design phase so as to create an environment where assessment results are valued and seen as an essential element of implementing improvement programs. Precision. USAID has supported the development of early grade

	assessment instruments that have been applied and tested in multiple country settings. Similar instruments have been developed by other partners. These efforts have led to consensus on essential constructs to be measured and effective measurement strategies. USAID will request full raw data set results (rather than simple aggregates of performance) of assessment activities so that more detailed analyses can be carried out where necessary. Reliability. There are a number of early grade assessment instruments and strategies available for adaptation to the country context. Technical support will be provided to countries for adaptation and interpretation of results. Timeliness. Assessment as a key element will be built into the design of all Goal 1 programming to support reporting and decision-making requirements.
Baseline Timeframe	Note that many USAID countries have already established baseline values for this indicator. Baseline for countries that have not yet carried out early grade reading assessments will be established either in 2011 or 2012.
Disaggregate(s)	Results will be disaggregated by sex in all countries, and reported separately for direct and indirect attribution to USG programming; Numerator/denominator (percent)

Indicator	3.2.1-28 The proportion of students who, by the end of the primary cycle, are able to read and demonstrate understanding as defined by a country curriculum, standards, or national experts
Definition	Proportion of students and learners who attain a country-defined threshold indicative of reading comprehension at the end of the primary cycle, as defined through the (national or sub-national) curriculum. Students and learners in formal and nonformal education programs focusing on reading should be included. The language of assessment will be determined by country policies and curriculum. Measures to be used and threshold levels will be tailored specifically to language, country context, and assessment strategy. Illustrative examples include country-specific benchmarks on national examinations that have satisfactory psychometric validity and reliability and limited corruption issues or context-specific levels of oral fluency, as defined by acceptable oral assessment standards; or demonstrating satisfactory levels of comprehension (e.g. 80%) as measured by simple recall questions on grade-level texts. A census of all the students and learners who received the treatment or intervention is not necessary. Rather, a statistical sample that is representative of that population is adequate. Those findings then may be extrapolated to the population. Numerator: Number of students and learners reading with comprehension at the end of the primary cycle (or nonformal equivalent). Denominator: Total number of students and learners at the end of the primary cycle (or nonformal equivalent). Note: Proportions must be reported separately for direct and indirect beneficiaries. Under each indicator and strategy goal, both direct and indirect beneficiaries should be reported. Direct beneficiaries are reached with direct USAID assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is <i>plausible attribution</i> – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental. USAID Missions, in concert with Washington, will be responsible for creating measures and defining thresholds.
Linkage to Long-Term Outcome or Impact	This indicator is an outcome measure of the highest order for Goal 1 of the Education Strategy, which calls for improved reading skills for 100 million primary school learners. While much of USAID's reading investment will be at the early grades, some interventions also will be at the upper primary level. For interventions including upper primary, this indicator will capture direct results of upper primary interventions.
Indicator Type	Outcome
Unit of Measure	Unit of measure is the student. Proportions of students/learners will be reported to indicate results against numbers of students/learners targeted. Proportions will range from 0 to 100%.

Use of Indicator	Reading skills are a key measure of education quality. Information generated by this indicator also will be used at the country level to monitor reading improvement programs and make corrections where necessary. It should also be noted that this indicator aligns with quality indicators being adopted by other development organizations, including FTI and DfID.
Data Source and Reporting Frequency	For students and learners in both formal and nonformal education programs, data will be generated through written reading comprehension assessments carried out at the country level at the end of primary school, except in cases of very low performance where oral assessment may be needed (see above). Assessments will be done at baseline and endline, and possibly at midline as well, using comparable assessments given at the same grades or their equivalents at the end of primary school. USAID will be responsible for ensuring that data are collected on outcomes, although these data may be collected through national standardized curriculum-based assessment systems conducted by partner governments, with or without USAID support. Note that the sampling approach must generate data representative at the level of USG interventions. If, for instance, programs intervene in only two provinces, data representative of those two provinces must be collected. Nationally-representative data cannot be disaggregated by province or district unless the sampling frame was designed to do so, and is large enough for this type of disaggregation.
Known Data Limitations	A note on each of these areas follows, but it is important to note that each of these will be concerns given that reporting on this indicator will be largely dependent on country systems. USAID will need to invest resources – both human and financial – in ensuring that tests, administration activities, and analysis address each of these areas. Validity. Country by country validity will be dependent upon the quality of available assessments, particularly in their ability to adequately measure literacy skills against the curriculum. USAID will verify the validity of the tests prior to reporting results, and if national tests are not suitable, will develop and use other tests. Integrity. Assessment at this level has become relatively standard in many countries and USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full raw data set results (rather than simple aggregates of performance) of assessment activities so that more detailed analyses can be carried out where necessary. Reliability. USAID will verify the reliability of tests prior to reporting results. Timeliness. Most countries carry out this level of assessment on an annual or bi-annual basis. In cases where the timeliness of the assessment

	schedule does not align with USAID needs, USAID will investigate the possibility of providing support for additional testing.
Baseline Timeframe	Many USAID countries have already established baseline values for this indicator. Baseline for countries who have not yet carried out reading comprehension assessments will be established either in 2011 or 2012.
Disaggregate(s)	Results will be disaggregated by sex in all countries, and reported separately for direct and indirect attribution to USG programming; Numerator, Denominator

Indicator	3.2.1-30 Primary Net Enrollment Rate (NER)
Definition	The primary net enrollment rate (NER) is the percentage of the primary school-age population that attends primary school. USAID uses the NER for a sample of countries receiving basic education funds, to indicate changes in access to basic education. U.S. assistance supports an increase in NER through a variety of activities designed to improve the quality of teaching and learning which helps to reduce barriers to student attendance and promotes effective classroom practices. High NERs are expected to lead to increases in school completion rates, higher educational attainment within the overall population, and country stability. Note that these NER data will be obtained through a third party source, so Missions need not report on NER.
Linkage to Long-Term Outcome or Impact	The NER provides a measure of access to schooling in a selected subset of countries supported by USAID. Access to schooling and to education more broadly, is closely correlated with country stability, which is directly relevant to Goal 3 of the Education Strategy.
Indicator Type	Output
Unit of Measure	Percentage of primary school-age population attending primary school
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be from third party sources, typically the UNESCO Institute for Statistics (UIS), and are available online. Reported annually
Known Data Limitations	Validity. Data represent the desired result. Integrity. UIS follows the same procedures year to year in collecting, analyzing, and verifying data from administrative sources (Ministries of Education) in country, and has a rigorous process for maximizing data quality. Precision. USAID will follow up with UIS on any apparent anomalies in the data, in particular when numbers seem at odds with expected trends. Reliability. Overall, procedures for ensuring data quality are well-established and sound. That said, in fragile and conflict-affected countries, data sometimes are unavailable or of doubtful quality. In these instances, USAID will triangulate with other data sources, notably household surveys, which often provide more accurate data – though not usually on an annual basis. Timeliness. Data are available annually, though it must be noted that NER data are available with up to a two-year time lag, in part to ensure high data quality.
Baseline Timeframe	Existing indicator, with years' of data available.
Disaggregate(s)	Sex.

Indicator	3.2.1-31 Number of teachers/educators/teaching assistants who successfully completed in-service training or received intensive coaching or mentoring with USG support
Definition	Number of teachers/educators/teaching assistants (hereafter, teachers) who have successfully completed an in-service training program to teach in schools or equivalent non-school based settings, with USG support (e.g. scholarships or a training program funded in whole or in part by USG). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. To be counted here, trainees must receive be at least 2 days (or 16 hours) total in training time. People trained as teaching assistants or coaches should be counted here. People trained under Fulbright or in sectors other than education who will be/are teaching in the formal or nonformal systems should be counted here, assuming relevance to goal 1 or goal 3. Numbers must be reported separately for Goal 1 and Goal 3 of the Education Strategy. For each goal, the teachers counted must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, teachers may be counted under both goals if they are beneficiaries of programming contributing to both goals. For instance, primary school teachers in a post-conflict country benefitting from USG training to provide psychosocial support to learners to improve access, and also taught to teach reading skills at the primary level, should be counted under both goals 1 and 3. When calculating the total numbers of teachers/educators/teaching assistants trained through in-service training, however, each teacher should be counted only once. Note that the total count for teachers trained should include only teachers/educators exposed to training contributing to either goal 1 or 3. Under each goal, report direct and indirect beneficiaries separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	Training teachers supports individual and institutional capacity building in countries. This indicator provides an overall sense of scope by giving a count of the total number of teachers/educators trained through in-service training. However, because the depth of USAID supporting interventions varies (e.g. this includes both short term and long term training), this is a limited indicator, meant to help ‘tell the story.’
Indicator Type	Output
Unit of Measure	Numbers of teachers/educators/training assistants
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be from review of project/program documents (usually training records) kept by implementing partners, USG, and host-country counterparts. Reported annually

Known Data Limitations	Validity. Data represent the desired result, the numbers of teachers trained. The validity of data will vary by country, and is dependent on avoiding double-counting the same trainees more than once for each goal, or by direct/indirect attribution. USAID will verify the validity of the lists and numbers of trainees prior to reporting results. Integrity. Reporting on trainees has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of trainees rather than aggregated numbers, in particular when numbers seem at odds with targets. Reliability. This training indicator, along with the in-service training indicator, is a departure from the previous standard indicator, which counted all teachers and educators trained through either approach. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USG-supported projects keep careful records of teachers trained, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines.
Baseline Timeframe	New indicator. This indicator is a subset of an existing standard indicator, which counted together the teachers trained in either pre- or in-service programs. Baseline will be established the first year the indicator is used.
Disaggregate(s)	Sex. Also disaggregate by goal 1 and goal 3, and by direct and indirect attribution.

Indicator	3.2.1-32 Number of teachers/educators/teaching assistants who successfully completed pre-service training with USG support
Definition	Number of individuals who have successfully completed a pre-service training program to teach in schools or equivalent non-school-based settings, with USG support (e.g. scholarships or a training program funded in whole or in part by USG), or with plausible USG attribution. Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. To be counted here, trainees must receive be at least 2 days (or 16 hours) total in training time. People trained as teaching assistants or coaches should be counted here. People trained under Fulbright or in sectors other than education who will be/are teaching in the formal or nonformal systems should be counted here, assuming relevance to each goal. Numbers must be reported separately for Goal 1 and Goal 3. For each goal, the teachers/educators/training assistants (hereafter, teachers) counted must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, teachers may be counted under both goals if they are beneficiaries of programming contributing to both goals. For instance, primary school teachers in a post-conflict country benefitting from USG training to provide psychosocial support to learners to improve access, and also taught to teach reading skills at the primary level, should be counted under both goals 1 and 3. When calculating the total numbers of teachers trained through pre-service training, however, each teacher should be counted only once. Note that the total count for teachers/educators trained should include only teachers exposed to training contributing to either goal 1 or 3. Under each goal, report direct and indirect beneficiaries separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	Training teachers and/or educators supports individual and institutional capacity building in countries. This indicator provides an overall sense of scope by giving a count of the total number of teachers/educators trained through pre-service training. However, because the depth of USAID supporting interventions varies (e.g. this includes both short term and long term training), this is a limited indicator, meant to help ‘tell the story.’
Indicator Type	Output
Unit of Measure	Numbers of teachers/educators/training assistants
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be from review of project/program documents (usually training records) kept by implementing partners, USG, and host-country

	counterparts. Reported annually
Known Data Limitations	Validity. Data represent the desired result, the numbers of teachers trained. The validity of data will vary by country, and is dependent on avoiding double-counting the same trainees. USAID will verify the validity of the lists and numbers of trainees prior to reporting results. Integrity. Reporting on trainees has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of trainees rather than aggregated numbers, in particular when numbers seem at odds with targets. Reliability. This training indicator, along with the pre-service training indicator, is a departure from the previous standard indicator, which counted all teachers trained through either approach. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USG-supported projects keep careful records of teachers trained, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines.
Baseline Timeframe	This indicator is a subset of an existing standard indicator, which counted together the teachers trained in either pre- or in-service programs. Baseline will be established the first year the indicator is used.
Disaggregate(s)	Sex. Also disaggregate by goal 1 and goal 3, and by direct and indirect attribution

Indicator	3.2.1-33 Number of textbooks and other teaching and learning materials (TLM) provided with USG assistance
Definition	The number of textbooks and other teaching and learning materials (hereafter, TLM) provided with USAID assistance. Some materials are designed, printed and published. Other materials are purchased and distributed. For the purposes of this indicator, the same material should be counted only once, in its final stage of USAID support. For instance, if one teachers' manual and one student textbook are developed for grade 1, and 2,000 copies of the manual and 100,000 copies of the textbook are printed and distributed with USAID support, the total count would be 120,000 TLM. Teaching and learning materials may include textbooks, student workbooks, supplementary reading books, educational tapes and CDs, library books, reference material in hard or electronic copies, and support material for educational radio and TV broadcasts. Small materials and supplies (e.g. pencils, small materials produced as hand-outs in training etc.), should not be counted. Numbers must be reported as a total and separately for Goal 1 and Goal 3. TLM for each goal must contribute directly to the achievement of that goal. For instance, under Goal 1, the TLM must focus on improving reading in primary school. And under Goal 3, TLM must be focused on improving access to schooling. In countries contributing to both goals, relevant materials may be counted under both goals. In the totals, however, materials should be counted only once. Operating Units reporting on TLM also must answer a question about whether TLM have been reviewed for gender bias. (If indicator used, ask: Have these materials been reviewed for gender bias (yes/no)? If so, how?). If the answer is yes, a narrative is required to explain the review process. A gender review involves checking TLM for signs of gender differences and inequalities based on relations between and among the sexes, based on their relative roles. In the narrative, operating units should explain what frame of reference or gender bias assessment approach was used in the review.
Linkage to Long-Term Outcome or Impact	Learning materials, including adequate materials for both students and teachers, is critical to supporting learning. This measure provides an overall sense of the scope of products resulting from investments in this area. However, because the depth of USAID supporting interventions varies, this is a limited indicator that is meant to help 'tell the story.'
Indicator Type	Output
Unit of Measure	Count of materials
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data from review of project/program documents from implementing partners, USAID, host-country counterparts. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of teaching and learning materials (TLM) produced and/or distributed. Integrity. Reporting on trainees has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to

	work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of TLM rather than aggregated numbers, in particular when numbers seem at odds with targets. Reliability. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of officials trained, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines
Baseline Timeframe	Existing indicator, so Missions with existing programs have years' worth of data.
Disaggregate(s)	Direct and indirect beneficiaries.

Indicator	3.2.1-34 Number of standardized learning assessments supported by USG
Definition	This indicator includes standardized learning assessments that can be used to measure learning in specific subject areas that can be measured against international standards (assessments such as PISA and PIRLS), as well as national and regional assessments (such as national achievement tests, regional tests such as SACMEQ, and tests of reading skills EGRA or ASER) that measure specific learning outcomes within a country. These tests are designed to be valid and to represent a reliable measure of change in learning levels over time, at the national level and often at the sub-national level. Not included in this variable are assessments that are project-specific tests used as performance measures against specific inputs (for example measuring learning gains within a set of pilot schools). This indicator is designed to measure assessments that have broad use as a tool for policy and for providing information on trends in learning achievement.
Linkage to Long-Term Outcome or Impact	Effective assessment of student achievement is key to raising learning outcomes, and to the provision of quality learning in conflict and crisis environments which is at the center of Goals 1 and 3. By supporting the development, implementation, and eventual utilization of assessments, USAID, host country governments, and our implementing partners will have a more informed understanding of what the education needs are in the country.
Indicator Type	Output
Unit of Measure	Number of assessments
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be provided from third party sources (such as online lists of surveys conducted by various organizations such as PISA or PIRLS), and from consultations with Ministries of Education. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, a count of standardized learning assessments. Integrity. Because the indicator is a count of reputable, valid assessments supported, there are no integrity issues. Precision. As with integrity, there are no precision issues, so long as assessments are not double counted. Reliability. USAID will review the data to ensure that the assessments counted are valid and reliable. Timeliness. USAID will consult country counterparts and third party sources, and will ensure the timeliness of data availability.
Baseline Timeframe	As the first year this indicator will be kept it will be the baseline.
Disaggregate(s)	Direct or indirect beneficiaries.

Indicator	3.2.1-35 Number of learners receiving reading interventions at the primary level
Definition	This indicator is designed to measure the number of primary-level students and learners exposed to interventions designed to improve reading skills at the primary level. Interventions may include a wide range of activities and approaches, including: remedial instruction, tracking and teaching students by ability groups, providing increased time on task, and other interventions. A reading intervention may include a component of pedagogy, materials, teacher coaching, mentoring or training, and improved accountability or reporting, perhaps to parent or community groups. Students and learners in both the formal and nonformal education systems should be counted here. Numbers must be reported separately for direct and indirect beneficiaries. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental.
Linkage to Long-Term Outcome or Impact	As part of the new education strategy's emphasis on developing reading skills at the primary level, these data will be used to track interventions designed to improve reading.
Indicator Type	Output
Unit of Measure	Number of students and learners
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data from project/program records from implementing partners, USAID, host-country counterparts. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of learners. Integrity. Reporting on numbers of learners has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. When numbers seem at odds with targets, USAID will request full lists of numbers of learners rather than aggregated numbers. Reliability. Partners have established, consistent systems for reporting results. Administrative data, from Ministries of Education, may use the same processes year to year, but have high incidence of missing or inaccurate data. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of learners reached, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timeliness.
Baseline Timeframe	New indicator; first year will provide baseline.
Disaggregate(s)	By direct/indirect beneficiaries.

Indicator	3.2.1-36 Number of schools using Information and Communication Technology due to USG support
Definition	The use of Information and Communication Technology (ICT) has potential to be an intervention that can leapfrog traditional barriers to education challenges. In this indicator, the term ICT is used to include all new and existing forms of technology designed to share and transmit information, including but not limited to: television, radio, internet, computers, DVDs, e-books, and mobile phones. Count the number of schools and nonformal education centers supported by USAID (using USAID funding) in the use of ICTs at the primary level. Do not count each school more than once, regardless of the number of ICTs used to teach reading. Note that schools should be counted only if ICTs are used in support of the achievement of Goal 1 or Goal 3.
Linkage to Long-Term Outcome or Impact	ICTs are expected to be used extensively in achieving results under Goal 1. ICTs also are key in expanding access to education, under Goal 3. In addition, this information will contribute to an understanding of the Agency's use of Science and Technology to achieve its overall goals.
Indicator Type	Output
Unit of Measure	Number of primary schools and non-formal education centers employing ICTs
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be provided by examination of project/program records from implementing partners, USAID, and host-country counterparts. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, the numbers of primary schools and nonformal education centers employing ICTs. Integrity. USAID will work with partners to ensure that there are standard approaches to collecting and reporting these data. Precision. When numbers seem at odds with targets, USAID will request full lists of schools and non-formal education centers rather than aggregated numbers. Reliability. USAID will work with partners to ensure that there are standard approaches to collecting and reporting these data. Timeliness. Most USAID-supported projects keep careful records for reporting on standard indicators, and these data are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timeliness.
Baseline Timeframe	As the first year this indicator will be kept it will be the baseline.
Disaggregate(s)	Goal 1 and Goal 3; direct/indirect beneficiaries

Indicator	3.2.1-37 Number of impact evaluations conducted
Definition	Impact evaluations measure the change in a development outcome as a result of an intervention, program, or treatment. “Gold standard” impact evaluations include random assignment into control and treatment groups, and include a counterfactual to control for factors other than the intervention that may account for the observed change. Quasi-experimental evaluations, which can include performance evaluation, are used when randomization is not possible. Performance and other quasi-experimental evaluations often employ methods including, but not limited to, regression discontinuity design, difference-in-difference methods, and instrumental variables to strengthen correlational relationships.
Linkage to Long-Term Outcome or Impact	Impact evaluations provide strong evidence for what works and what does not. As a part of the focus on evidence based programming under the new education strategy, it is important to track the number of impact evaluations conducted and their use.
Indicator Type	Output
Unit of Measure	Number of impact evaluations
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data from review of project/program documents. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, a count of impact evaluations done. USAID will ensure that the counts include only impact, and not performance, evaluations. Integrity. The indicator is a simple count of impact evaluation completed; there are no integrity issues. Precision. As with integrity, there are no precision issues, so long as performance evaluations are not counted. Reliability. USAID will ensure that only impact evaluations are counted. Timeliness. USAID will have these data available on demand.
Baseline Timeframe	As the first year this indicator will be kept it will be the baseline.
Disaggregate(s)	Goal 1 or Goal 3.

Indicator	3.2.1-38 Number of laws, policies, regulations, or guidelines developed or modified to improve primary grade reading programs or increase equitable access
Definition	This indicator captures information on quantifiable systems and policy level activities. Examples of actions that may be counted include the development or modification of laws, policies, regulations or guidelines in areas such as school finance, assessment, teacher recruitment and selection, etc. To be counted, actions must have, as their ultimate purpose, improving equitable access to education (goal 3), or the quality of education services (goal 1).
Linkage to Long-Term Outcome or Impact	Provides a generalized reporting structure for tracking interventions that work on system strengthening through policy reform, legislation and system strengthening
Indicator Type	Output
Unit of Measure	Number of laws, policies, regulations or guidelines
Use of Indicator	As interventions support long term gains it is important to document the number and type of interventions for future reference.
Data Source and Reporting Frequency	Project/program documents from implementing partners, US government, and partners. Annual reporting
Known Data Limitations	Validity. Data represent the desired result. However, it can be hard to determine the extent of the level of involvement of the USAID when a new law, policy, or regulation is passed or modified. In the database, in the narrative section, the Mission should explain how USAID support was a contributing factor. Integrity. The indicator is a simple count; there are no integrity issues. Precision. As with integrity, there are no precision issues. Reliability. USAID will ensure that the same approach is taken, year to year, to reporting on this indicator. Timeliness. USAID will work with partners to ensure that these data are available in keeping with USAID's needs.
Baseline Timeframe	Baseline needs to be established
Disaggregate(s)	Goal 1 and Goal 3

Indicator	3.2.1-39 Number of classrooms built or repaired with USG assistance
Definition	“Classrooms” are safe and secure spaces in which organized group learning takes place. Classrooms range from environmentally-appropriate, roofed structures without walls, to traditional four-walled structures with a roof and windows. This indicator does not include temporary classrooms (such as tents, open spaces set aside for instruction) frequently found in refugee settings. Individual classrooms should be counted if a whole classroom block is built or repaired.
Linkage to Long-Term Outcome or Impact	Classrooms of acceptable quality are an essential component of education, making instruction possible and encouraging parents to send their children to school. Adequate school buildings positively impact access to education.
Indicator Type	Output
Unit of Measure	Number of discrete classrooms
Use of Indicator	Reporting, accountability, and project adjustment
Data Source and Reporting Frequency	Implementing partners, USAID and partners Annual frequency
Known Data Limitations	Validity. Data represent the desired result. Integrity. The indicator is a simple count; there are no integrity issues. Precision. As with integrity, there are no precision issues. Reliability. USAID will ensure that the same approach is taken, year to year, to reporting on this indicator. Timeliness. USAID will work with partners to ensure that these data are available in keeping with USAID’s needs.
Baseline Timeframe	Baseline needs to be established
Disaggregate(s)	NA

Indicator	3.2.1-40 Number of USG supported schools or learning spaces meeting criteria for safe schools program
Definition	Safe school criteria include: Schools or learning spaces are secure environments for children/learners; provide a stimulating and supportive environment for children; are built on existing structures and capacities within a community; use a fully participatory approach for the design and implementation; provide or support integrated services and programs; are inclusive and non-discriminatory. See UNICEF's Child Friendly School Checklist: http://www.unicef.org/lifeskills/index_7260.html#A%20Framework%20for%20Rights-Based.%20Child-Friendly
Linkage to Long-Term Outcome or Impact	In crisis and conflict-affected environments, lack of security and safety in schools are major reasons why students do not consistently attend. Therefore this indicator is a proxy for increasing access. The likelihood for there to be safety risks in and around schools is often higher in crisis and conflict contexts. This indicator helps gauge the extent to which schools serve as a protective environment for learners in these contexts.
Indicator Type	Output
Unit of Measure	School level Reviewed annually
Use of Indicator	Reporting, accountability and project adjustment
Data Source and Reporting Frequency	Project/program documentation from implementing partners, school administration. Annual frequency.
Known Data Limitations	Validity. Data represent the desired result. USAID will ensure the uniform application of standards for safe schools. Integrity. The indicator is a simple count; there are no integrity issues. Precision. As with integrity, there are no precision issues. Reliability. USAID will ensure that the same approach is taken, year to year, to reporting on this indicator. Timeliness. USAID will work with partners to ensure that these data are available in keeping with USAID's needs.
Baseline Timeframe	Baseline needs to be established
Disaggregate(s)	NA

Indicator	3.2.1-41 Total number of person hours of teachers/educators/teaching assistants who successfully completed in-service training or received intensive coaching or mentoring with USG support
Definition	Number of person hours of teachers/educators/teaching assistants who have successfully completed an in-service training program to teach in schools or equivalent non-school based settings, with USAID support (e.g. scholarships or a training program funded in whole or in part by USAID). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. To be counted here, trainees must receive be at least 2 days (or 16 hours) total in training time. Training hours for people trained as teaching assistants or coaches should be counted here. Training hours for people trained under Fulbright or in sectors other than education who will be/are teaching in the formal or nonformal systems should be counted here, assuming relevance to goal 1 or goal 3. <i>Training hours should be counted only for those teachers/educators/teaching assistants counted in the related indicator:</i> Number of teachers/educators/teaching assistants who successfully completed in-service training or received intensive coaching or mentoring with USG support. For each goal, the hours of training successfully completed by teachers/educators/teaching assistants (hereafter, teachers) must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, hours successfully completed may be counted under both goals if they are beneficiaries of programming contributing to both goals. Under each goal, report direct and indirect beneficiary hours separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental. This indicator uses the following equation to express the number of USG-supported training hours that were completed by training participants: Step 1: For each training program: Hours of USG supported training course x Number of people completing that training course. Step 1: Sum hours across training programs.
Linkage to Long-Term Outcome or Impact	Training teachers and/or teaching assistants supports individual and institutional capacity building in countries. This indicator provides a sense of the magnitude of time spent on in-service training.
Indicator Type	Output
Unit of Measure	Total numbers of hours of in-service training completed by individual teachers
Use of Indicator	Indicator used for planning and reporting purposes, by Missions,

	USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Data will be from review of project/program documents (usually training records) kept by implementing partners, USAID, and host-country counterparts. Reported annually
Known Data Limitations	Validity. Data represent the desired result, the total numbers of hours completed by teachers trained. The validity of data will vary by country, and is dependent on an accurate estimate of training hours and trainees. Integrity. Reporting on trainees has been systematized across USAID partners. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of trainees rather than aggregated numbers. Reliability. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of teachers trained, and they now will be asked to keep data on average number of training hours across courses as well. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines.
Baseline Timeframe	New indicator. Baseline will be established the first year the indicator is used.
Disaggregate(s)	Sex. Also disaggregate by goal 1 and goal 3, and by direct and indirect beneficiaries.

Indicator	3.2.1-42 Total number of person hours of teachers/educators/teaching assistants who successfully completed pre-service training with USG support
Definition	Number of person hours of teachers/teaching assistants who have successfully completed a pre-service training program to teach in schools or equivalent non-school based settings, with USAID support (e.g. scholarships or a training program funded in whole or in part by USAID). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. To be counted here, trainees must receive be at least 2 days (or 16 hours) total in training time. Training hours for people trained as teaching assistants or coaches should be counted here. Training hours for people trained under Fulbright or in sectors other than education who will be/are teaching in the formal or nonformal systems should be counted here, assuming relevance to goal 1 or goal 3. <i>Training hours should be counted only for those teachers/educators/teaching assistants counted in the related indicator:</i> Number of teachers/educators/teaching assistants who successfully completed pre-service training or received intensive coaching or mentoring with USG support. For each goal, the hours of training successfully completed by teachers/educators/teaching assistants (hereafter, teachers) must be only those reached by programming contributing to each respective goal. Note however that in countries contributing to both goals, hours successfully completed may be counted under both goals if they are beneficiaries of programming contributing to both goals. Under each goal, report direct and indirect beneficiary hours separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental. This indicator uses the following equation to express the number of USG-supported training hours that were completed by training participants: Step 1: For each training program: Hours of USG supported training course x Number of people completing that training course. Step 1: Sum hours across training programs
Linkage to Long-Term Outcome or Impact	Training teachers and/or teaching assistants supports individual and institutional capacity building in countries. This indicator provides a count of the total number of teachers/teaching assistants trained through pre-service training.
Indicator Type	Output
Unit of Measure	Numbers of teachers/teaching assistants
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.

Data Source and Reporting Frequency	Data will be from review of project/program documents (usually training records) kept by implementing partners, USAID, and host-country counterparts. Reported annually
Known Data Limitations	Validity. Data represent the desired result, the numbers of teachers trained. The validity of data will vary by country, and is dependent on avoiding double-counting the same trainees. USAID will verify the validity of the lists and numbers of trainees prior to reporting results. Integrity. Reporting on trainees has been systematized across USAID partners, over years of usage of this indicator. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results. Precision. USAID will request full lists of trainees rather than aggregated numbers, in particular when numbers seem at odds with targets. Reliability. This training indicator, along with the pre-service training indicator, is a departure from the previous standard indicator, which counted all teachers and teaching assistants trained through either approach. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of teachers trained, and these are readily available on demand. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines.
Baseline Timeframe	This indicator is a subset of an existing standard indicator, which counted together the teachers trained in either pre- or in-service programs. Baseline will be established the first year the indicator is used.
Disaggregate(s)	Sex. Also disaggregate by goal 1 and goal 3, and by direct and indirect beneficiaries

Indicator	3.2.1-43 Total number of person hours of administrators and officials successfully trained
Definition	Number of person hours education officials (public or private) or administrators of education programs, funds or institutions receiving training in aspects of their current positions, including areas such as management and quality assurance for improving reading skills at the primary level (Goal 1), or supporting the re-integration of conflict-affected youth into the formal or nonformal education systems (Goal 3). Successful completion requires that trainees meet the completion requirements of the structured training program as defined by the program offered. Number of hours must be reported separately for Goal 1 and Goal 3. For each goal, the official/administrator hours counted must be only those reached by programming contributing to Goal 1 and Goal 3. In countries that are contributing to both goals, official/administrator hours may be counted under both Goal 1 and Goal 3 only if they are beneficiaries of programming contributing to both goals. Under each goal, report direct and indirect beneficiary hours separately. Direct beneficiaries are reached with direct USG assistance (funded in part or in whole by USG). Indirect beneficiaries are affected through a follow-on or indirect effect but where there is plausible attribution – such as countries taking a USG-funded pilot intervention to scale, with no additional USG funding; or donor and country harmonization around a common technical approach, in which USG has been instrumental. This indicator uses the following equation to express the number of USG-supported training hours that were completed by training participants: Step 1: For each training program: Hours of USG supported training course x Number of people completing that training course. Step 1: Sum hours across training programs
Linkage to Long-Term Outcome or Impact	USAID training supports capacity building for host country education administrators and officials and their institutions.
Indicator Type	Output
Unit of Measure	Number of officials and administrators
Use of Indicator	Indicator used for planning and reporting purposes, by Missions, USAID/Washington, Congress, and other stakeholders.
Data Source and Reporting Frequency	Program documents and records from implementing partners, USAID, host-country counterparts. Reported annually.
Known Data Limitations	Validity. Data represent the desired result, the total numbers of hours completed by trainees. The validity of data will vary by country, and is dependent on an accurate estimate of training hours and trainees. Integrity. Reporting on trainees has been systematized across USAID partners. USAID will continue to work with partner governments to reinforce the importance of integrity in reporting of results.

	Precision. USAID will request full lists of trainees rather than aggregated numbers. Reliability. USAID will verify the reliability of data prior to reporting results. Timeliness. Most USAID-supported projects keep careful records of teachers trained, and they now will be asked to keep data on average number of training hours across courses as well. In cases where the data are not available in keeping with USAID needs, USAID will work with partners to revise data collection and availability timelines.
Baseline Timeframe	Baseline will be established in year 1.
Disaggregate(s)	Sex; goal 1 and goal 3; direct and indirect.

Indicator	3.2.1-44 Number of teachers in USG supported programs trained on how to support learners' psychosocial well-being
Definition	The term "teachers" refers to both formal and non-formal teaching personnel and can include skilled trainers that provide support to formal and non-formal learning environments. "Training in psychosocial well-being" refers to building teachers' capacity to provide a healing and supportive environment for learners affected by crisis and conflict. The <i>Guiding Principles on Mental Health and Psychosocial Support</i>, developed by the IASC provide the following framework: promote safe learning environments, make formal and non-formal education more supportive and relevant, strengthen access to education for all, prepare and encourage teaching assistants to support learners' psychosocial well-being and, strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties. See IASC Guidelines on Mental Health and Psychosocial Wellbeing: http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
Linkage to Long-Term Outcome or Impact	Training teachers in psychosocial well-being aids teachers in recognizing signs of distress in learners and take steps to address distress. Learners as well as their teachers are uniquely affected by crisis and conflict. When teachers are sensitized to learners' needs and able to better help them with adverse family or social situations, they are also able to protect themselves from burnout or occupational stress. Therefore, teachers trained in the provision of psychosocial support are better able to protect and foster the development of children, youth and adult learners throughout the crisis or conflict. The desired long-term outcome is to contribute to increased sustainability of education efforts in crisis and conflict-affected environments.
Indicator Type	Output
Unit of Measure	Number of teachers
Use of Indicator	Planning, reporting, accountability, project adjustments
Data Source and Reporting Frequency	Project/program documentation from implementing partners, school administration Annual frequency
Known Data Limitations	Validity. Data represent the desired result. USAID will ensure the uniform application of standards for training in providing psychosocial support. Integrity. The indicator is a simple count; there are no integrity issues. Precision. As with integrity, there are no precision issues. Reliability. USAID will ensure that the same approach is taken, year to year, to reporting on this indicator. Timeliness. USAID will work with partners to ensure that these data are available in keeping with USAID's needs.
Baseline Timeframe	Baseline needs to be established
Disaggregate(s)	Sex

3.2.2 - Higher Education

Indicator	3.2.2-33 Number of USG-supported tertiary education programs that include experiential and/or applied learning opportunities
Definition	Experiential learning is an educational practice of supplementing the classroom setting with a work experience in the real world. Applied learning is having the ability to apply the learning gained in a classroom to real world situations. Both require some structured work experience integrated with classroom learning to apply the learning.
Linkage to Long-Term Outcome or Impact	The inclusion of experiential learning and/or applied learning opportunities in educational programs increases participants' readiness to enter the labor market upon completion of the program, and is therefore a marker of greater capacity. The problem addressed in activities in support of this indicator is the overly theoretical nature of much of the curricula. Agriculture students need to get their shoes muddy. By monitoring the number of USG-supported higher education institutions implementing this basic pedagogical feature, we can link our funding to greater quality.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	Indicator used for decisions regarding targeting experiential/applied learning in curriculum reform interventions.
Data Source and Reporting Frequency	Implementing partners' annual reports.
Known Data Limitations	Validity – No issues. Integrity - Dependent on institutions accurately categorizing their programs as experiential and/or applied learning. Precision - Same limitation as integrity. Reliability - No issues. Timeliness – No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	None

Indicator	3.2.2-35 Number of U.S.-host country joint development research projects
Definition	Joint research projects are those undertaken as part of a U.S.-supported university partnership program or other similar arrangement. The joint research serves to strengthen the host country institution and draw it into application and market priorities.
Linkage to Long-Term Outcome or Impact	Joint research projects contribute to the capacity of higher education institutions to produce workforce with relevant skills for the market. A vibrant and market-focused research program will produce better graduates and will enable the university to contribute more effectively to development goals.
Indicator Type	Outcome
Unit of Measure	Number
Use of Indicator	To adjust the number and sector of joint projects in future programs.
Data Source and Reporting Frequency	U.S. and host country universities. Annual.
Known Data Limitations	Validity – No issues. Integrity – No issues. Precision - No issues. Reliability – No issues. Timeliness - No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	By sector.

Indicator	3.2.2-36 Number of USG-supported tertiary programs with curricula revised with private and/or public sector employers' input or on the basis of market research
Definition	Private or public sector employers' input signifies a substantive involvement with tertiary curriculum developers to assure labor market needs are taken into account. As appropriate, such input may be derived from published research. Operating units should specify in their indicator reference sheets and PPR narratives the role of U.S. partners in the process of curricular development or revision.
Linkage to Long-Term Outcome or Impact	Measures progress toward making higher education curricula more relevant to the needs of the host country labor market, though input from private and public sector employers. Assuming qualified teachers capable of teaching the more market-oriented curricula, and students performing in the classroom, such curricula will contribute to students being better prepared for the demands of the market upon entering the workforce. This output indicator is related to 3.2.2.2-a (outcome), which addresses skills certification, the basis for curriculum alignment with market needs.
Indicator Type	Output
Unit of Measure	Number of programs
Use of Indicator	Indicator used for decisions regarding targeting market input to curriculum reform interventions.
Data Source and Reporting Frequency	Partner staff at U.S.-supported host country universities, via implementing partners' annual reports.
Known Data Limitations	Validity – No issues. Integrity – Dependent on university curriculum developer valuing the input from non – academic sources. Precision – No issues. Reliability - No issues. Timeliness - No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	None

Indicator	3.2.2-37 Percentage of graduates from USG-supported tertiary education programs reporting themselves as employed
Definition	Programs are parts of a tertiary institution, such as a USG-supported faculty or department, or the university if USG support is directed at the whole institution. Employed is a job or self-employment within one year of graduation. Calculated by dividing the number of graduates employed (including self-employed) (numerator) by the number of graduates of the same programs minus the number going on for further education, training, or other non-employment activity (denominator.)
Linkage to Long-Term Outcome or Impact	Outcome indicator for Element level: the ultimate test of whether a tertiary institution produces workforce with relevant skills. However, see comments below under Data Limitations/Validity.
Indicator Type	Outcome
Unit of Measure	Percentage
Use of Indicator	For accountability for results of assistance to tertiary institutions and for modification or design of new programs.
Data Source and Reporting Frequency	Data from graduates and contact data from universities via Higher Education for Development (HED) for HED partnership programs, and missions and other Operating Units for other tertiary programs.
Known Data Limitations	Validity. – Problematic, especially as an indicator on the Element level, because local and national economies may have few jobs even for graduates with relevant skills. Improvement in getting jobs is dependent on areas outside of manageable interest. Integrity. - Objectivity of self-reporting. Precision. - Difficulty of locating graduates; reluctance to report employment situation. Reliability. – Difficulty of replicating data. Timeliness - Difficulty of relying on timeliness of universities to provide contact data on graduates.
Baseline Timeframe	FY 2012
Disaggregate(s)	By sex; Numerator/denominator (percent)

Indicator	3.2.2-38 Number of USG-supported tertiary education programs that adopt policies and/or procedures to strengthen transparency of admissions and/or to increase access of underserved and disadvantaged groups
Definition	Policies and/or procedures must be written down and official and must also be implemented. Policies that support increased access to tertiary education and workforce development programs by underserved and disadvantaged groups include, but are not limited to: transparent admissions, external or internal admissions tests, conditional admission dependent on performance, and remedial programs and courses, all with the goal of opening up university admission to a broader segment of society than the traditional elite. Definition of underserved and disadvantaged is determined by host country social and economic measures and will vary by country. Operating units should specify this in their in their PMP indicator reference sheet and in the PPR, as well as a list of the policies and procedures supported. Programs are parts of a tertiary institution, such as a USG-supported faculty or department, or the university if USG support is directed at the whole institution.
Linkage to Long-Term Outcome or Impact	Adoption and implementation of policies and procedures are an outcome that will have a long-term impact on universities, making them able to draw on a wider range of talent across society.
Indicator Type	Outcome
Unit of Measure	Number of programs
Use of Indicator	To measure the preconditions in the way of policies and procedures to greater access. Results would be used to plan interventions in this area.
Data Source and Reporting Frequency	Partner universities, via Higher Education for Development (HED) annual report for EGAT/ED HED partnerships and other Operating Units for other programs. Annual.
Known Data Limitations	Validity - Definition of written policy and procedure may vary across institutions. Integrity – University officials may want to make their institutions look good. Precision – Same as integrity. Reliability – No issues. Timeliness – No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	Four ways: by policy and procedure to strengthen transparency of admissions and to increase access of underserved and/or disadvantaged groups.

Indicator	3.2.2-39 Number of US-supported tertiary educational programs that develop or implement industry-recognized skills certification
Definition	This indicator measures progress toward aligning tertiary programs with the needs of the labor market. Skills certification is a system attesting to the fact that a graduate has mastered a set of skills agreed to by industry and tertiary institutions. The tertiary institution may develop skills certification lists and programs in consultation with public or private sector employers or may implement certification developed by others, i.e. may design curriculum along skill lists developed by industry. In both cases, implementation means framing the curriculum around skills in demand by the market. Development and implementation of programs around these skills sets are crucial steps to aligning university offerings with the needs of employers.
Linkage to Long-Term Outcome or Impact	This measure will show the number of USG-supported tertiary programs preparing students for a standardized skill certificate, which will help align tertiary programs with the needs of the market, a key requirement for success in increasing capacity of tertiary institutions to produce workforce with relevant skills.
Indicator Type	Outcome
Unit of Measure	Number of tertiary programs
Use of Indicator	Used for targeting institutions for skills certification assistance.
Data Source and Reporting Frequency	Data from universities' annual reports; interviews with host and U.S. universities. Reported annually.
Known Data Limitations	Validity - No limitations Integrity– Difficult to be sure that skills list is basis for course content across the board. Precision - None Reliability - None Timeliness - None
Baseline Timeframe	FY 2012.
Disaggregate(s)	None

Indicator	3.2.2-40 Number of academic research initiatives whose findings have been replicated, applied, or taken to market
Definition	This indicator tracks the quality, application, and marketing of research initiatives undertaken by the host country or by a partnership between host country and US tertiary institutions. Replicated means research successfully repeated by a peer academic institution or other research center, public or private, in either the host country or elsewhere, usually a precursor to application. Applied means used in a practical application outside of the original research setting. Taken to market means produced and sold on the market.
Linkage to Long-Term Outcome or Impact	This outcome indicator tracks the degree to which academic research is applied and reaches the market. Replication is a pre-cursor to application.
Indicator Type	Outcome
Unit of Measure	Number.
Use of Indicator	Indicator used for decisions regarding targeting interventions to encourage progress in the linear process of research-replication-application-going to market.
Data Source and Reporting Frequency	Data on specific research activities and marketing of research products from university research centers, local business organizations, and Chambers of Commerce. Reported annually.
Known Data Limitations	Validity. – No issues. Integrity. – Dependent on researchers and markets not withholding data because of fear of losing market advantage. Precision. – No issues. Reliability. - No issues. Timeliness. - No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	None

Indicator	3.2.2-41 Number of individuals from underserved and/or disadvantaged groups accessing tertiary education programs
Definition	Underserved and disadvantaged may refer to regions of the country, social groups such as ethnic minorities, particularly poor economic groups, or physically handicapped people. Definition of underserved and disadvantaged determined by host country social and economic measures and will vary by country. Operating units should define them in their Performance Management Plan indicator reference sheets and in the Performance Management Plan.
Linkage to Long-Term Outcome or Impact	An important consideration in Goal 2 of the Education Strategy is opening up access to groups which had hitherto limited opportunity to enter tertiary education or workforce development programs. Although this is a sensitive issue, some means of measuring improvement in access is needed and will show a direct link of access to the ability of such programs to produce a quality workforce with relevant skills.
Indicator Type	Outcome
Unit of Measure	Number of individuals.
Use of Indicator	To see which groups need further programmatic interventions to increase their access to which type of programs. Indicator used for planning and reporting purposes, by USAID/Washington, mission, and other OUs.
Data Source and Reporting Frequency	Application and admission records of USG-supported tertiary and workforce programs. Annual
Known Data Limitations	Validity – Difficulty of varying definitions of underserved and disadvantaged. Integrity – No issues. Precision – No issues. Reliability – Related to validity issues. Timeliness – No issues.
Baseline Timeframe	FY 2012.
Disaggregate(s)	Sex; social/ethnic vs. economic category.

Indicator	3.2.2-42 Number of tertiary institution faculty or teaching staff whose qualifications are strengthened through USG-supported tertiary education programs
Definition	This indicator tracks the number of host country institutional staff participating in long-term training programs to improve their credentials as part of university strengthening programs. The locale of training may be the U.S., host country, or a third country. Training can be part of university partnerships, joint student or faculty exchange, part of a joint research project, or other programs of host country university strengthening, all with the objective of improving the academic qualifications of host country university staff. This is traditionally a major component of partnership strengthening activities.
Linkage to Long-Term Outcome or Impact	Improving the qualification of faculty is a major tool in increasing the capacity of host country tertiary institutions.
Indicator Type	Output
Unit of Measure	Number
Use of Indicator	To track the number of training programs as part of the overall partnership activity and to adjust numbers for future programs.
Data Source and Reporting Frequency	U.S. and host country institutions, data in annual partnership reports, TraiNet participant database. Annual.
Known Data Limitations	Validity – No issues. Integrity – No issues. Precision – Numbers for U.S. programs are straightforward and most directly got from TraiNet, the mechanism through which U.S. visas are obtained. TraiNet data on in country and third country programs may be less accurate. Reliability – No issues. Timeliness - No issues.
Baseline Timeframe	FY 2012
Disaggregate(s)	By sex and sector

3.3 – Social and Economic Services and Protection for Vulnerable Populations

Definition of Vulnerable Populations

Vulnerable Populations include children, youth, and adults affected by violence, disease, poverty, or circumstances that place them at an especially elevated risk of abuse, exploitation, illness (morbidity), and/or death (mortality). Vulnerable populations identified for targeted assistance include, but are not limited to:

1. children who have lost one or both parents to AIDS, live in households made increasingly vulnerable because of HIV/AIDS, or were born to HIV-positive mothers;
2. orphaned children (those who have lost one or both parents due to any cause);
3. those who are injured, ill, or made homeless as a direct result of a disaster and require immediate assistance;
4. persons with disabilities—defined as those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (definition from the Convention on the Rights of Persons with Disabilities);
5. separated or unaccompanied children, including children living outside of family-based or family-like care, such as orphanages or non-family-based group setting
6. refugees (someone who, owing to a well-founded fear of being persecuted for reasons of identity, including, but not limited to race, ethnicity, religion, gender identity, sexual orientation, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it);
7. internally displaced persons, having been forced to leave their homes or places of habitual residence, in particular as a result of, or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural- or human-made disasters, and who have not crossed an international border;
8. Women and children of female-headed households;
9. children affected by armed conflict, including those who are associated with an armed force or armed group as “child soldiers” or as cooks, porters, spies or for sexual purposes, and those living in a context in which conflict has caused, for example, interruption and disintegration of basic services and sources of social protection (e.g., interruption of schools and health systems, homes, and religious institutions, collapse of political authority and rule of law, torture and other forms of ill-treatment, administrative detention, enforced displacement, sexual exploitation, and hazardous work);
10. children and adults subject to trafficking in persons (i.e., in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or subject to recruitment, harboring, transportation, provision, or labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery
11. children subject to harmful practices of child labor, including all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labor, prostitution, the production of pornography or for pornographic performances, the production and trafficking of drugs as defined in the relevant international treaties, or work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children;

12. Children and adults exposed to all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including gender based violence and sexual abuse (gender-based violence refers to any harm that is perpetrated against a person's will and results from power inequities that are based on gender roles—the term highlights the relationship between women's subordinate status in society and their increased vulnerability to violence, however, in some cases men and boys may also be victims of gender-based violence, since violence may be physical, sexual, psychological, economic, or socio-cultural);
13. Children and adults with a well-founded fear of being persecuted for reasons of identity, including, but not limited to race, ethnicity, religion, gender identity, sexual orientation, nationality, membership of a particular social group or political opinion;
14. Street children, such as those engaged in some kind of economic activity, ranging from begging to vending, who must go home at the end of the day and contribute their earnings to their family, and children who actually live on the street; and
15. Children living in extreme poverty.
16. Any person whose humanity and human dignity is intentionally disrespected, in an effort to dehumanize and therefore disassociate that person from the full range of universal human rights protections and freedoms that otherwise the person would have a claim to by the simple fact of being human.

3.3.1 – Policies, Regulations, and Systems

Indicator	3.3.1-13 Number of social protection policy reforms drafted, adopted or implemented with USG support
Definition	Number of social protection policy reform policies drafted, adopted, and/or implemented as a result of USG technical support/input. (Higher = Better) Provides information about progress in the development of a country's social protection policies (policies drafted). It also provides proxy measures for social protection regulations (policies adopted) and for systems (policies implemented).
Linkage to Long-Term Outcome or Impact	This output provides the necessary foundation work for outcome level changes in social services policies.
Indicator Type	Output
Unit of Measure	Number of policy reforms drafted, adopted or implemented
Use of Indicator	Can be used to monitor progress
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Unit count of policies Annual reporting
Known Data Limitations	A “reform” is not a defined unit of measure that permits one to meaningfully conclude that implementing twelve “reforms” is four times better than implementing three “reforms”—or even better at all. Moreover, there is no common definition of how to define the parameter of “a reform”. Missions should include a narrative when reporting on this indicator explaining the relevance and impact of any reform.
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Disaggregate(s)	None

3.3.2 – Social Services

Indicator	3.3.2-8 Number of vulnerable people benefitting from USG-supported social services
Definition	Number of vulnerable people receiving services from programs funded in whole or in part by the USG. (Higher = Better) Simple output measure to enable the roll up of vulnerable people assisted through USG resources.
Linkage to Long-Term Outcome or Impact	Provides an essential link to higher order outcome measure
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	Monitor progress
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Reviews of service records Annual reporting
Known Data Limitations	Program self reporting is always subject to variability of inter rater reliability
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Disaggregate(s)	• Sex • Other targeted vulnerable people • Victims of torture • Vulnerable children • War victims • Persons with disabilities • Males with disabilities • Females with disabilities

Indicator	3.3.2-13 Number of service providers trained who serve vulnerable persons
Definition	Number of service providers trained who serve vulnerable persons. (Higher = Better) Tracks improvement in the capacity to provide social assistance and social service programs. Also serves as an indicator of a government's commitment and capacity to protect its vulnerable populations.
Linkage to Long-Term Outcome or Impact	This measure provides an initial basis for getting to higher order outcomes.
Indicator Type	Output
Unit of Measure	Number of service providers
Use of Indicator	Tracks capacity improvement
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Unit count from training records Annual reporting
Known Data Limitations	Program self reporting is subject to error
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Disaggregate(s)	Sex

Indicator	3.3.2-15 Number of USG-assisted organizations and/or service delivery systems strengthened who serve vulnerable populations
Definition	Number of organizations or service delivery systems strengthened (providing better or more efficient services) with USG resources. (Higher = Better) Tracks improvement in the capacity to provide social assistance and social service programs. Also serves as an indicator of a government's commitment and capacity to protect its vulnerable populations.
Linkage to Long-Term Outcome or Impact	Improvement in systems delivery is essential to long term outcome achievement
Indicator Type	Output
Unit of Measure	Number of organizations and/or delivery systems
Use of Indicator	Tracks progress towards outcomes
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Unit count from project records Annual reporting
Known Data Limitations	Program self reporting is subject to error
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Disaggregate(s)	Local NGO (non-DPO); DPO

3.3.3 – Social Assistance

Indicator	3.3.3-9 Number of people benefitting from USG-supported social assistance programming
Definition	Number of people receiving assistance (cash, food, or other in-kind) from programs supported in whole or in part through USG resources. (Higher = Better) Simple output measure to enable the roll up of USG-supported programming addressing social assistance needs.
Linkage to Long-Term Outcome or Impact	Essential precursor output to long term outcomes
Indicator Type	Output
Unit of Measure	Number of people
Use of Indicator	Tracks basic progress in service delivery
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Unit count from project records Annual reporting
Known Data Limitations	Program self reporting is subject to error
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Responsibility	DCHA/PPM
Disaggregate(s)	• Female-headed household • Food insecure • HIV-affected • Sex • Other targeted vulnerable people

Indicator	3.3.3-15 Number of USG social assistance beneficiaries participating in productive safety nets
Definition	The number of people participating in USG-supported social assistance programming with productive components aimed at increasing community assets, household assets, or strengthening human capital. (Higher = Better) Provides information on the amount of USG assistance aimed at increasing self-sufficiency in vulnerable populations.
Linkage to Long-Term Outcome or Impact	This output is a link to higher order self sustaining outcomes
Indicator Type	Output
Unit of Measure	Number of beneficiaries
Use of Indicator	Tracks program progress
Data Source and Reporting Frequency	Review of Project reports/Program review results Documents/Unit count from project records Annual reporting
Known Data Limitations	Program self reporting is subject to error
Baseline Timeframe	Baseline timeframe needs to be established by the Operating Unit
Disaggregate(s)	• HIV-affected • Number of men • Number of women • Other targeted vulnerable group • Food insecure